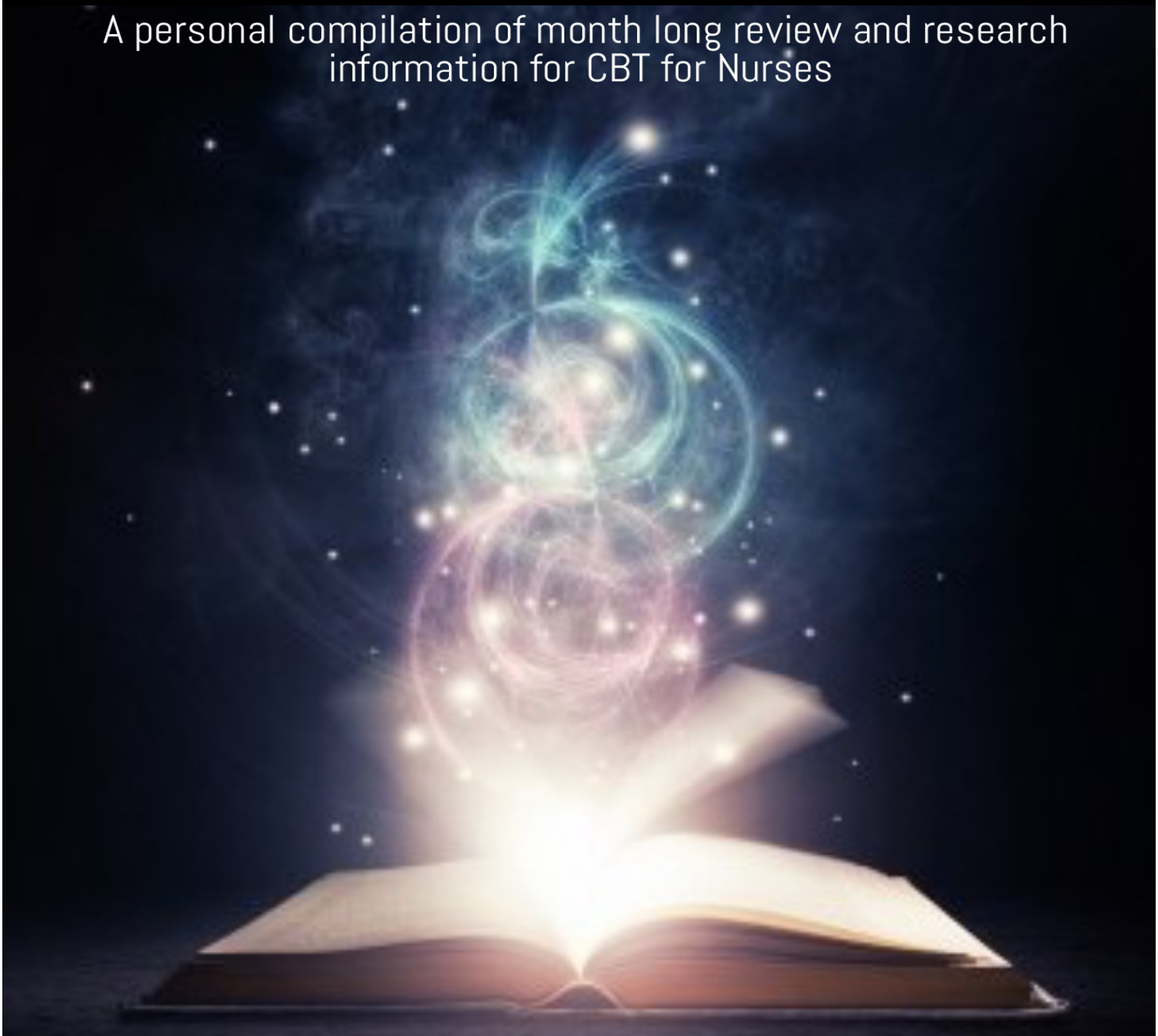
Ms. Karen Faye's

First Edition

The Notebook

A personal compilation of month long review and research information for CBT for Nurses



Edited by Ms. Jae M. C.

FOREWORD

"The Notebook" is an intellectual property of Ms. Karen Faye. All details, information, diagrams and facts included in this document were from her month long review and research as preparation for her CBT for Nurses. First posted in the CBT group in jpeg file and been shared in different format afterwards.

I transcribed this MSWord format of "The Notebook" as my own version of the review material for the sole purpose of using it for my CBT preparation. No data was removed from the original handwritten version of "The Notebook" with few information added and several changes were done to improve the diagrams and presentation of the material.

Upon using this great work of art, kindly be aware of some things. Firstly, relying solely on this document for CBT review is not advisable, as you will need more resources and materials to fully prepare yourself for the exam. This is also not a substitute for other review materials needed for CBT preparation. Secondly, the data included in this review material was based from the author's own research and may change or vary depending on the source of information. Moreover, the material's format is in bulleted form and has limited details thus, FURTHER RESEARCH will be needed to fully understand and grasp the whole concept of each topic. Lastly, with the flow of numerous inquiries and conversations about the validity and reliability of the material, we decided to change its format and include our details on it to protect the authenticity of "The Notebook" as a shared personal review material and not as a professional and legal document. Again I will reiterate, this is a personal review material not professionally made to gain profit in any kind and must be used together with countless published materials available both in paper and online.

Furthermore, this material was shared, as Ms. Karen Faye and I believe that we must extend our blessings and encourage each and everyone to study and pursue their dreams. Our intention is to share our efforts and blessings to others and not to create a different perception on materials to be used for CBT review. It is known that in order to pass the CBT, it requires numerous sources of information to acquire necessary knowledge and it is vital to consult different resources to conform an accurate and final answer.

Credits to Ms. Karen Faye for being selfless and generous in sharing her hard work with everyone and for being an inspiration to others to study well and persevere in achieving their dreams.

I would like to personally thank you for your warm and encouraging messages. It is my pleasure to share this with everybody. Ms. Karen Faye and I were both glad and thankful that this material was helpful to everyone and had reached lands miles away from ours. You may download and share it freely with your friends and colleagues.

May we continue to inspire each other and God bless us all.

Best regards,

Ms. Jae M. C.

-Jae M. C. 2018-

DOMAIN 1

- The Francis Report
- Accountability- individuals are responsible for their own action and may be asked to justify them.
- Responsibility- being responsible for one's own action.
- Delegation- authority can be delegated but responsibility cannot be. Responsibility is fixed.

NMC'S CODE OF CONDUCT (SUMMARY)

1. Care of each patient is the primary concern.
2. Treat patients as individuals.
3. Do not discriminate.
4. Treat patients kindly.
5. Respect confidentiality.
6. Disclose information that might pose risk or harm to a patient.
7. Advocate for the patient.
8. Collaborate with other members of the multidisciplinary team.
9. Maintain clear provisional boundaries.
10. Monitor quality and maintain safety.
11. Consult and take advice from colleagues.
12. Delegate effectively.
13. Manage risks.
14. Report concerns.
15. Provide high standard of care at all time.
16. Evidence-based practice.
17. Keep up-to-date.
18. Keep clear and concise records (documentation)
19. Act with integrity/honesty.
20. Uphold the reputation of the Nursing profession.

4 KEY PRINCIPLES

1. Prioritize people
2. Practice effectively
3. Preserve safety
4. Promote professionalism and trust

RECORDKEEPING

- Document evidence
- Liability/accountability
- Provides continuous flow of care with colleagues.
- Helps address any complaint
- Must be legible, signed and dated

RAISING CONCERNS

- To safeguard the patient's health and well being.
- Act without delay
- Raise any concern with the patient who are at potential risk
- Advocate for the patient
- Must act with the best interest of the patient

FRANCIS REPORT

- Sir Robert Francis
- Mid Staffordshire Hospital
- Between 2005-2009, final report in 2013
- Putting patients first
- NO to poor quality Nursing service
- NO to high mortality rates
- NO to negligence
- YES to accountability
- YES to patient safety
- YES to patient centered care
- YES to compassionate healthcare delivery
- 6 C's
    - Care
    - Compassion
    - Commitment
    - Courage
    - Competence
    - Communication

NURSING PRPCESS AND CARE DELIVERY

-Should deal with one patient at a time

1. Assessment - mobility, ht., wt., skin integrity, medications, risk of current/falls,
2. Planning
3. Implementation
4. Evaluation – revision of the care plan can occur at this stage

DRUGS

Delivery with controlled drugs – 2 nurses to check and sign the medication.

Consent – verbal/written (e.g. blood tests, new medications, operations) to be considered as VALID, it must be VOLUNTARY and INFORMED, and the person consenting must have the capacity to make decision.

- Voluntary- made by the person himself or herself must not be influenced by pressure.
- Informed- all information must be given
  -benefits -risks -alternatives
- Capacity- the person can understand and the capacity must be respected
- Without capacity- go ahead and give treatment if it is in the person's best interest with permission of the relatives/ friends of the patient

SITUATION WHEN CONSENT IS NOT NEEDED

1. Emergency treatment to save the patient's life
2. Immediate additional emergency procedures
3. Severe mental health condition
4. Requires hospital treatment for severe mental health condition, but self-harmed/ attempted suicide while competent and is refusing treatment.
5. Risk to public health (rabies, cholera, TB)
6. Severely ill and living in unhygienic condition

RELEVANT LEGAL TERMS

1. Mental Health Act (1983, amended 2003)
    - Legal rights that apply to people with severe mental health problems
    - Enables some patients to be detained in the hospital
2. Mental Capacity Act (2005)
    - Protect people who cannot make decisions for themselves
3. The Court of Protection
    - Legal body that overseas the operation of the Mental Capacity Act
4. Advance Decision
    - Advance directive/living will
    - Legally binding document that sets out in advance the treatment and procedures that someone is refusing to have

NATIONAL INSTITUTE FOR HEALTHCARE EXCELLENCE (NICE)

- Independent public body that provides national guidance and advice to improve health and social care in England
- Offers evidenced-based recommendations
- Guidelines:
    - Preventing and managing specific conditions
    - Way to promote and protect good health or prevent ill health
    - Configuration, staffing and provision of health and social care services
    - How national and local public sector organizations and partnerships can improve the quality of care and services
    - Care and services suitable for particular populations, groups or people.

INDEPENDENT ADVOCACY

- Way to help people have a stronger voice and to have as much control as possible with their own lives.
- Keep individuals/groups to get information they need so that they can make real choices about their circumstances.

DELEGATION

- Nurse are accountable to whatever tasks we delegate
- Make sure that the other person is competent to do what you have asked and fully understand the instructions they are given.
- Adequately supervised and supported so they can provide safe and compassionate care
- The outcome of any tasks delegated to someone meets the required standard

SELF-ADMINISTRATION OF MEDICINES BY PATIENTS, PARENTS OR CARERS

Levels of Self-administration

a. Level 1 (Dependent) – Nurse supervises administration with medicines
b. Level 2 (Shared) - Patient administers all medication under supervision (Registrant only supervises, RN holds the key)
c. Level 3 (Independent) – Patient administers all medications without supervision and is given custody to the bedside locker

Level 2/3 – Partial self-administration (on specific medications).
-Patient wants to retain control with administering a specific medication but does not want to administer the other medications.

SPEED SHOCK

- a sudden adverse physiological reaction to IV medications/drugs that are administered too quickly.
- Signs: flushed face, headache, tight feeling in the chest, irregular pulse, loss of consciousness and cardiac arrest.

RECOMMENDED PRE-OPERATIVE FASTING TIME- 6-12 hours

MALNUTRITION UNIVERSAL SCREENING TOOL (MUST)

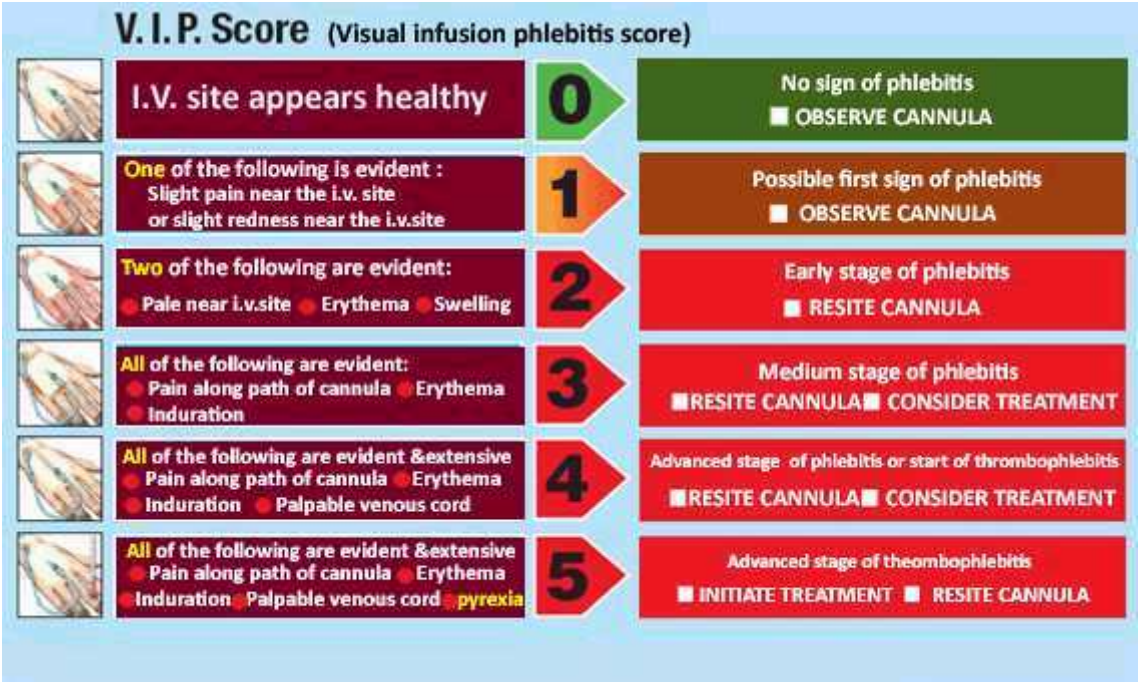
3 Criteria:

1. Current weight status using BMI
2. Unintentional weight loss
3. Acute disease effect

0- LOW – monitor weight
1- MEDIUM – monitor food intake for the past 3 days
2- HIGH – refer to dietician

VISUAL INFUSION PHLEBITIS (VIP) SCORE

- Empowers healthcare workers so that IV catheters can be removed at the 1st indication of phlebitis



NATIONAL EARLY WARNING SCORE (NEWS)

- Determine the degree of illness with a patient prompting critical care interventions
    1. Respiratory rate
    2. Oxygen respirations
    3. Temperature
    4. Systolic BP
    5. Pulse rate
    6. Level of consciousness (alert, voice, pain, unconsciousness)

- Score of 5 or more – admission to ICU/ increased likelihood of death

SCORE	MONITORING	RESPONSE
0	Minimum 12hrs	• Continue routine NEWS monitoring
1-4	Minimum 4-6hrs	• Inform RN who must assess the patient • RN decide if frequency of monitoring will be increased • Escalation with critical care is required
5 or more	Hourly	• RN to urgently inform medical team • Urgent assessment by a clinician • Critical care with monitoring facilities
7 or more	Continuous monitoring of VS	• RN immediately inform the medical team (Specialist registrar level) • Emergency Assessment by the medical team with critical care competencies (with advance airway skills) • Transfer to an level 2 or 3 care facility

FINE SITES FOR IM INJECTIONS

1. VENTROGLUTEAL – free of major nerves and blood vessels
   - Muscle is large and well defined
   - Site of choice for IM injections

2. DELTOID – easily accessible
   - 2.5 to 5cm below the acromial process
   - Avoid the radial and brachial nerves
   - Maximum volume to be administered is 1ml

3. DORSOGLUTEAL (BUTTOCKS) – former site of choice
   - Used for deep IM & z-track injections
   - Avoid the sciatic nerve
   - Gluteus muscle has the lowest drug absorption rate, increased overdose
   - In adults: up to 4ml can be given

4. RECTUS FEMORIS – deep IM and Z-track
   - Rarely used
   - Easily accessed for self-administration or for infants

5. VASTUS LATERALIS – deep IM and Z-track
   - Easily accessed
   - No major blood vessels/nerves
   - Better option for obese patient
   - Up to 5ml can be infected

METHODS OF ADMINISTERING IV DRUGS

1. CONTINUOUS INFUSION – IV delivery with medication fluid at constant route over a prescribed time provided to adhere a controlled therapeutic response
   - Drugs to be administered are highly diluted – maintenance with steady blood levels with the drug is required.

- DANGER. Bolus injection to counter the additions should be made to the infusion fluid and the container incited a number of times to ensure mixing.

2. INTERMITTENT INFUSION- administration with small volume infusion 25-250ml between 5minutes to 2hrs.
   - May be given as specific dose at one time or repeated intervals over a period of 24hrs
   - Used when:
     - Peak plasma level is required
     - The drug dictates a specific dilution
     - The drug will not remain stable
     - Patient is on restricted intake of fluids
   - Can be piggy backed

3. DIRECT INTERMITTENT INJECTION – aka intravenous push or bolus; involves injection of a drug from a syringe into the injection port with the administration set or directly into a vascular access device (VAD)
   - Used when:
     - Bolus injection which is given rapidly over seconds (as in emergency e.g Adrenaline)
     - With drug can't be further diluted or does not require dilution
     - Peak blood level is required and can't be achieved be small volume infusion

YELLOW CARD SCHEME

- Helps monitor the safety of all products in the UK to ensure they are acceptably safe for patients and those that use them.
- Collects information on suspected problems or incidents involving:
  - Side effects-adverse drug reactions
  - Medical device adverse event
  - Defective medicine
  - Counterfeit medications/medical devices
  - Safety concerns for electronic cigarettes

INFECTION PREVENTION AND CONTROL

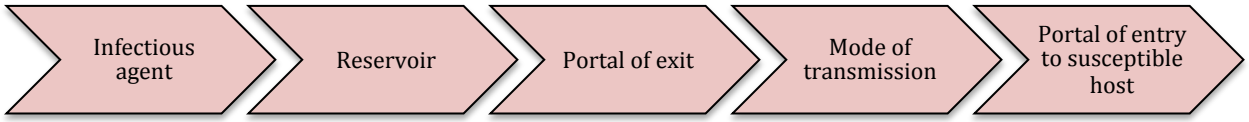
- Clinical application with microbiology in practice
- Activities intended to protect people from infections

IMPORTANT TERMS

- INFECTIOUS AGENTS- transmitted from one person to another or from environment to person.
- PATHOGEN- micro-organisms that is capable of causing infection
- COLONIZATION- micro-organisms present on or in a person but not currently causing any harm
- HEALTHCARE ASSOCIATED INFECTION (HCAI)- infection acquired as a result of healthcare related intervention
  Former term: Hospital-acquired infection
- CROSS INFECTION- transmission of infectious agent between patients within the healthcare setting

- UNIVERSAL PRECAUTION- universal blood and body fluid precaution. No individual can be regarded as "risk free".
- STANDARD PRECAUTION- actions that should be taken in every care situation to protect patients and others from infection.
  - Includes:
    - 5 moments of hand hygiene
    - Came in the use and disposal of sharps
    - Correct use of PPE
    - Providing care with adequately decontaminated equipment
    - Safe disposal of waste
    - Safe management of used linen

CHAIN OF INFECTION



Signs and Symptoms of Infection:

- Heat
- Swelling
- Pus
- Pain
- Redness
- General malaise

PRIORITY FOR ISOLATION	SCORE
Low	0-20
Medium	25-35
High	35+

WASTE COLOR CODE
(Royal Marsden pg 90-92)

1. **YELLOW** – disposal by incineration
   - For diagnostic exams: e.g. gloves, apron, dressing
   - Higher chance of contamination
2. **ORANGE** – WASTE WHICH MAY BE TREATED, ATP'S, ALTERNATING PLANS
   - PPE'S e.g. wipes, aprons, bandages, ATP's
3. **PURPLE** – biohazard waste, cytotoxic and cytostatic waste, by incineration
   - e.g. chemotherapy, needles, syringes, drip sets
4. **YELLOW/BLACK** – offensive/hygiene waste, goes to the landfill or by incineration
   - e.g. diapers, napkin, colostomy bags, incontinence pads, catheter bags
5. **RED** – Anatomical waste for incineration (infected)
   - e.g. blood bags, sharps, blood preserves
6. **BLACK** – Domestic/Municipal waste
   - e.g. household wastes, disposable cups, sandwich wrappers
7. **BLUE** – Medicinal waste for incineration
   - e.g. expired medications, tablets, blister pads, liquids in bottles

8. **WHITE** – Amalgam waste
    - e.g. dental waste

SOURCE ISOLATION PRINCIPLES OF CARE

- Linens – must be placed in a red water soluble alginate polyethylene bag
- Waste – orange waste bag should be kept in the isolation room for disposal of all waste generated in that room.

LEAVING THE ISOLATION ROOM

- Clean hands with soap and water or alcohol hand rub
- Do not use alcohol hand rub when patient requires ENTERIC PRECAUTION: wash with soap and water (Clostridium Difficile spores are resistant to alcohol)

WOUND MANAGEMENT

- Wound – break in the skin
    - Physical, mechanical or thermal
    - Result of an underlying medical or physiological disorder

        1. Physical Damage – pressure ulcers
        2. Mechanical Damage – abrasions, grazes, lacerations, surgery, bullet wounds, bite, etc.
        3. Thermal Damage – flames, frostbite, chemicals, radiation, friction, electricity
        4. Medical or Physiological Disorder – autoimmune, endocrine, dermatological or hematological disorders, systemic infections

- Wound Healing – physiological process that repair and restore damaged skin tissue

- Acute Wounds – proceed through the healing process in a timely manner
    - Less than 4-6 weeks healing time without complications
- Chronic Wounds - presence of underlying pathology
    - With persistent state of inflammation
    - Heal by secondary intention (granulation tissue is produced)
    - e.g. pressure ulcers, dehisced surgical wounds
- Non-healing wounds – e.g. malignant fungating wounds
    - Primary goal: maximize patient's comfort and control symptoms such as exudate, odor, pain
    - Tissue viability service (decides whether a wound is non-healing)

PRESSURE ULCER CATEGORY

1. Intact skin
2. Partial thickness – shallow ulcer
3. Full thickness – subcutaneous fats
4. Full thickness with exposed bone, muscle and/or tendon

T – Tissue
I – Infection/Inflammation
M – Moisture balance
E – Edge advancement

TYPES OF WOUND HEALING

- Primary Intention – clean wound, suture/skin adhesive
- Secondary Intention – wound gapping, irregular, boundaries can't be brought together, contraction, epithelialization
- Tertiary Intention – wound not sutured
- Healing delayed, left open the closed primarily after a few days

PATIENT ASSESSMENT - medical history, nutritional, psychological & social assessment

WOUND ASSESSMENT

1. Blister – serum/blood
2. Abscess – filled with pus
3. Superficial/Partial thickness skin loss – epidermis/dermis
4. Full thickness – involves subcutaneous layers
   – blind ended tract
5. Wound fistula – abnormal passage from an internal organ to the body surface

TYPES OF WOUND TISSUE
(Royal Marsden pg 944)

DRESSINGS	WOUND TISSUE	DEFINITION
Hydrogel, hydrocolloid foam, honey-based foam	Necrotic	Black, hard dry & leathery/gray in color, devitalized tissue
Alginate, hydrofibre, honey based, absorbent dressing/foams	Slough tissue	Devitalized tissue but yellow/waxy white in color, requires debridement
Iodine/ silver/ alginate/ honey-based	Infected	Appears red in color, wounds which extends pass the margins of the wound
Hydrocolloid, adhesive/non-adhesive	Granulating tissue	Moist, appears red or dark pink with small bumps caused by capillary growth
Hydrocolloid, silicon based, semi-permeable	Epithelializing	White or pink in color. Wound is getting smaller and healing. Should be kept warm & moist to facilitate epithelial growth.

WOUND MANAGEMENT – based on identifying and treating underlying causes. Addressing patient concerns and wound bed preparation.

WOUND BED PREPARATION PRINCIPLES

a. Wound debridement
b. Infection prevention and control
c. Effective exudate management

DEBRIDEMENT – removal of necrotic, devitalized, sloughing or infected tissue or foreign bodies from a wound

METHODS:

1. Autolytic – the body gradually sheds itself

2. Bio-surgery – sterile larvae
3. Sharp debridement – sterile blade/scissors
4. Surgical debridement – remove or drain devitalized tissue

WOUND EXUDATE – fluid produced from wounds

PHASES OF WOUND HEALING

1. Hemostasis (minutes)
2. Inflammatory (1-5 minutes)
3. Proliferative (3-24 days) - granulation tissue
4. Maturation (21 days onward) – re-epithelialization

DOMAIN 4

NURSING LEADERSHIP

5 LEADERSHIP STYLES

1. SERVANT LEADERSHIP – leaders influence and motivate others by building relationships and developing the skills of the individual team members.
    - Characteristics:
        - Listening
        - Awareness
        - Acceptance
        - Persuasion
        - Commitment to the growth of others
        - Building community within the organization

2. TRANSFORMATIONAL LEADERSHIP – have charisma to communicate, vision, confident to act in a way that inspires others, gives encouragement and praise

3. DEMOCRATIC LEADERSHIP – encourages open communication and staff participation. Focus on quality improvement of systems and process.

4. AUTHORITARIAN LEADERSHIP – the leader makes all the decision without considering input from the staff. Negative reinforcement and punishment are often used to enforce rules. Works perfectly in emergencies or chaotic situations where there is little time for decision-making.

5. LAISSEZ-FAIRE LEADERSHIP – provides little or no direction or supervision and prefers to take hands-off approach. Used by new, inexperienced leaders

COMMUNICATION – vital in risk prevention
- verbal and non-verbal

TEAM – group of people with variety, experiences, skills and talents working together towards a common goal

ELEMENTS OF TEAM WORK

- TRUST – allows team members to be honest about their strength and weakness, know that they can rely on each other
- EMPATHY – ability to imagine yourself in another person's experience and feelings
- ATTITUDE – manner, disposition, feeling or position with person or thing
  - leave personal problems at the door when you arrive to work
- MUTUAL RESPECT – recognizing and attempting to uphold the rights and dignity of another person. Accepting each other's view and the right to have them

DOMAIN 5

ADULT/GENERAL NURSING

- **5 A DAY** – eating a variety of fruits and vegetables may help to reduce the risk of heart disease, stroke and some cancers.
    - Contributes plenty of vitamins and minerals
    - What counts?
        - Fresh, frozen, chilled, canned, 100% juice or dried fruits and vegetables all count.
        - Weighs approximately 80grams
        - Potatoes, jams, cassava, do not count because they are starchy foods
        - Foods and vegetable contained in convenience packs (ready meals, pasta sauces, soups, puddings)
        - Convenience food can be high in fat, sugar, salt and should be taken in moderation

ASSISTIVE DEVICES FOR WALKING

Canes and walkers – made with lightweight material with rubber tip at the bottom

Interventions:

1. Stand at the affected side of the patient when ambulating, use of gait or transfer belt may be necessary.
2. Handle should be at the lock of the patient's greater trochanter.
3. The patient's elbow should be fixed at a 15-30degree angle.
4. Instruct the client to hold the cane 4-6 inches to the side of the foot.
5. Instruct the client to hold the cane in the hand of the unaffected side so that the cane and weaker leg can work together with each step.
6. Instruct patient to move the cane at the same time as the affected leg.
7. Advice patient to inspect the rubber tip regularly for worn places.

Hemicanes or Quadripod canes – used for clients who have the use of only one upper extremity.

- Hemicanes provides more security than a quadripod can. However, both types provide more security than a single tipped cane.
- Interventions:
    1. Position the cane at the client's unaffected side with the straight non-affected side adjacent to the body.
    2. Position the cane 6 inches from the client's unaffected side with the hand grip level at the greater trochanter.

Walker – mechanical device with 4 legs for support.

- Interventions:
    1. Stand adjacent to the client on the affected side.
    2. Instruct patient to put all 4 points of the walker flat on the floor before putting weight on the hand piece.
    3. Instruct client to move the walker forward followed by the weaker foot and then the unaffected foot.
    4. Nursing care: teach client to hold upper bars of the walker at each side then to move the walker forward and step into it.

Cane – Types: single, straight-legged cane, tripod cane, quadcane

- Nursing care: teach patient to hold cane in the hand opposite the affected extremity and to advance the cane at the same time the affected leg is moved forward.

AVPU SCALE (ALERT, VOICE, PAIN, UNRESPONSIVE)

- System by which a first aider, ambulance crew or healthcare professional can measure and record the patient's responsiveness, indicating their Level of consciousness.
- Simplification of Glasgow Coma Scale (GCS)

A – ALERT – the patient is fully awake
V – VOICE – the patient makes some kind of response when you talk to them (grunt, moan or slight move of a limb)
P – PAIN – patient makes response on application of pain stimulus (e.g. central pain stimulus or peripheral pain stimulus)
U – UNRESPONSIVE – or unconscious, patient does not give any eye, voice or motor response to voice or pain.

- In first aid, AVPU score with less than A is considered an indication to get further help.
- In the hospital, caregivers may consider and AVPU score with less than A to be patient's normal baseline.
- Alert may be subdivided into a scale of 1 to 4 (time, person, place & event)
- AVPU assessment to be followed by GCS if AVPU score is below A.
- AVPU is not suitable for long term neurological observation of the patient GCS scale is more appropriate.

AVPU	**vs**	**GCS**
Alert		15
Voice		12
Pain		8
Unconscious		3

NMC STANDARDS FOR MEDICINE MANAGEMENT

NMC primary purpose: protection of the public

- sets standards for nurses & midwives in the UK (education, training & conduct)
- Provides advice and guidance to registrant on professional issues.

STANDARD 1 – METHOD

Registrants must only supply and administer medicinal products in accordance with one or more of the following process:

1. Patient specific direction (PSD)
2. Patient medicines administration chart (also called Medication Administration Record – MAR)
3. Patient Group Direction (PGD)
4. Medicine Act Exemption
5. Standing Order
6. Homely Remedy protocol
7. Prescription forms

STANDARD 2 – CHECKING

Registrants must check any direction to administer a medicinal product

STANDARD 3 – TRANSCRIBING

As registrants you may transcribe medication for one "direction to supply/administer" to another form of "direction to supply/administer". (e.g. discharge letter, transfer letters, etc.)

TRANSPOSING – transcribing term for Pharmacists

STANDARD 4 – PRESCRIPTION MEDICINES

Registrants may in exceptional circumstances label from stock and supply a clinically appropriate medicine to a patient, against a written prescription (not PGD), for self-administration or administration by another professional, and to advise on its safe and effective use.

9 RIGHTS OF MEDICINE MANAGEMENT

1. Patient
2. Medicine
3. Route
4. Time
5. Dose
6. Documentation
7. Reason/Action (confirm the rationale for the medication & review long term medications)
8. Response/Form (desired effect of the drug)
9. Requirement

LEGAL REQUIREMENTS FOR THE SCHEDULES OF CONTROLLED DRUGS

Schedule 1 – highest level of control

- Research use only
- Possession & supplying is prohibited
- e.g. cannabis, LSD

Schedule 2 – require written prescription

- Full controlled drug requirements (opioids & major stimulants)
- e.g. heroin, cocaine, methadone, amphetamines
- Safe custody, prescription requirements, requisitions necessary, records to be kept in CD registrants
- Identify the person collecting CD, 28 days validity with prescription, 30 days maximum duration that can be prescribed.

SCHEDULE 3 – CD no register (minor stimulants, tramadol, barbiturates

- same as schedule #2 but without the requirement to maintain register
- No schedule drugs can be given as an emergency supply except phenobarbiturates or related drugs for epilepsy treatment
- New prescription after 6 months or 5 refills

SCHEDULE 4 – CD prescription requirements and safe custody requirements do not apply

- e.g. benzodiazepines, anabolic steroids, growth hormones
- Emergency supplies are allowed
- New prescription after 6 months

SCHEDULE 5 – needs invoice retention for 2 years

- e.g. low dose opioids
- Validity with prescription in 6 months
- Dispensed as any other prescription with or without prescription if state law allows

WATERLOW SCORING FOR PRESSURE ULCERS

10+ (at Risk)	Specialized memory foam mattress 100cm cushion
15+ (High Risk)	Alternating pressure overlays mattress, bed systems Specialized gel/foam cushion
20+ (Very High Risk)	Dynamic mattress Specialized cushion Low air loss & alternating air mattress

Criteria:

- ✓ Built (weight for height)
- ✓ Skin type
- ✓ Sex, age
- ✓ Malnutrition screen tool
- ✓ Continence
- ✓ Mobility

Special risks: Tissue malnutrition, neurological deficit, major surgery/trauma

WOUND CLOSURE
(Royal Marsden pg 955)

1. Suturing

Types:

a. Interrupted suture – simplest, not easily broken/weakened
b. Continuous – quick to perform, easy to remove
c. Subcuticular – continuous or interrupted placed horizontally in the dermis, avoids suture marks on the skin, easy to remove

ADVANTAGE	DISADVANTAGE
- Secure closure - Necessity of local anesthesia - Provides good conditions for wound cleansing	- Must be performed by an experienced practitioner - Wrong technique can lead to delayed healing. - Time consuming to perform and to remove

	- Whole suture may unravel if there is breakage - Difficult to drain wound - If sutures are not placed at the correct depth, a "step" can occur resulting to delayed healing.
2. Adhesive Skin Closure Strips	
- No local anesthesia required - Tissue damage is minimal - Strips are cheap and simple to apply and remove	- Only suitable for clean wound - Shear forces may cause blistering on the skin - Edema on the skin site may cause taped wound edges to invert causing delayed healing
3. Tissue Adhesive	
- No local anesthesia required - Produces strong flexible bond - Less painful - Produce GOOD cosmetic results	- Suitable for clean wounds - Requires second person to assist - Not suitable over joints, wounds on the eyes, mouth & scalp
4. Skin Clips	
- Used on many types of surgical incisions - Low operating time & trauma - Produce uniform tension	- More expensive than suture - Must be inserted by an experienced practitioner - Failure to align may cause scar deformity - Extractor is required for clip removal

NEGATIVE PRESSURE WOUND THERAPY

- Previously known as the TOPICAL NEGATIVE PRESSURE (TNP)
- Application of negative (-) pressure across the wound bed to promote healing
- Benefits: management of exudate, decrease in odor, increase local blood flow, decrease in dressing changes and improvement in quality of life
- INDICATIONS:
    - Chronic wounds
    - Diabetic or neuropathic ulcers
    - Post-operative and dehisced surgical wounds
    - Partial thickness burns, fistulae
    - Skin flap, grafts, traumatic wounds
- CONTRAINDICATIONS:
    - Grossly contaminated wounds
    - Malignant wounds
    - Untreated wounds
    - Wounds with necrotic tissue or eschar

PRINCIPLES OF WOUND DRESSING

1. Allows gaseous exchange
2. Maintain optimum temperature and pH
3. Forms effective barrier to bacteria
4. Removal of dressing is without pain or skin stripping
5. Acceptable to the patient
6. Highly absorbent
7. Cost effective
8. Require minimal replacement
9. Appropriate to the wound

ELECTROCARDIOGRAM (ECG)

Universal Donor – Type 'O'
Universal Recipient – Type 'AB'

EXAM TIPS:

- Nurse who exhibits MORAL COURAGE involves taking action to do what is right even when there might be negative consequences
- Post Lumbar tap
  - Increased heart are, decreased BP & level of consciousness, dilated pupils (BRAIN HERNIATION)
- Student request to be with tissue viability nurse, it is possible if you SUPERVISE them.
- New RN – problems with assumptions
  - PRIORITISE PEOPLE
- RN – patient advocacy
  - Taking a public stand on quality issues and educating the public on public interest issues.
- PROTECTED MEAL TIME
  - Patient gets enough time to eat food without distraction while staff focuses on people who need help with eating.
- RN not allowing the client to sleep without finishing his meal
  - Challenge the situation immediately as this is related to the dignity of the patient and raise your concern
- 14 Principles of Management – Henry Fayol
- Young manager Nurse to Old nurses
  - Give assignments clearly, taking staff expertise into consideration
- Do not cause fall among elderly:
  - NSAIDS
- Reinforces with diagnosis of VITAMIN B12 DEFICIENCY
  - Beefy tongue
- BIOHAZARD SPECIMEN
  - Labeled with Biohazard
  - Self sealing bag
  - Must be transported to the laboratory in a secure box with a fastenable lead
- RN discuss the patient's wishes to the family
  - ADVOCATE
- ACCOUNTABILITY
  - answerable to oneself & others for one's own action
- BROAD SPECTRUM ANTIBIOTICS
  - should be started within the first hour of recognition of severe sepsis
- BLOOD CULTURE
  - Should be taken before antimicrobial therapy is started
- RESPIRATION
  - Transport of oxygen from the outside air to the cells within the tissues and the transport of carbon dioxide in the opposite direction.
- Does not value the dignity and respect in Nursing Care
  - We are honest and open about our point of view and what we can and cannot do.
- ESSENCE OF CARE BENCHMARKING
  - Comparing, sharing and developing practice in order to achieve and sustain best practice.

- The CODE purpose
  - Tool for educating prospective nurses and midwives
- ORAL CORTICOSTEROID – Side Effect:
  - Glaucoma and Fluid Retention
- TRAIT/ GREATMAN Theory
  - Leaders are born and not made
- Client with wound infection – CONTACT PRECAUTION. When should nurse wear disposable gloves?
  - When providing care within 3 feet from the patient
- After surgery – how long?
  - Evidence suggest that dressings are no longer required in a wound with good opposition 72hours
- In case of FIRE
  - Do RACE: Rescue, Alarm, Contain, Extinguish
- SLOW PROGRESSIVE DISEASE
  - No definite cure, only symptomatic management (TERMINAL)
- TRAVELLER'S DIARRHEA
  - Absorbents such as Kaslin is ineffective
- GLOMERULONEPHRITIS – Dyspnea
  - Albumin loss causes decrease in oncotic pressure which cause water retention causing fluid retention in alveoli
- UNCONDITIONAL POSITIVE REGARD
  - According to Roger's Theory – accepting the way they are
- Symptoms of COMPENSATED SHOCK
  - Vasoconstriction and Normal BP, Tachycardia
- UNMANAGE STRESS
  - Serious complications: hypertension, increased risk of infection
- LEVOTHYROXINE instruction
  - Take 30 minutes to 1 hour before breakfast
- Variance Analysis performed in all clients – CONTINUOUSLY
- The RN cares for a client with a wound in the late regeneration phase
  - Transparent film for protection
- Community Hospital provides:
  - Rehabilitation
  - Physiotherapy
  - Palliative care
  - Respite care
  - Psychiatry
  - Acute & Primary care
  - Occupational therapy
  - Step-down care for discharged patients
- A patient who is 160cm in height and 54kgs in weight.
  Drug ordered: 70mg per m^2. The BSA is $1.55m^2$
  Calculate the dose: Desired dose x BSA
  $1.55m^2$ x 70mg = $108.5mg/m^2$
- 40mg to be given in 3 divided doses at 80mg per kg body weight.
  How many mg per dose?
  (Desired dose x kg body weight) / 3 doses: 40 x 80 = 3200 / 3 = 1067mg
- May be delegated to unlicensed assistive personnel: assisting with performing incentive spirometry

- Signs of Opioid Toxicity
  - CNS depression
  - Papillary miosis
  - Respiratory depression(cyanosis)
  - Bradycardia
- According to post registration education policy in UK, a staff that observes the chest tube insertion is considered to have:
  - INFORMAL training.
- DENTURE – signs of related stomatitis
  - Patches with shiny redness on the cheeks, tongue, gums & palate
- DATA PROTECTION 1998
  - governs the protection of personal data in UK
- Stages to Raise a Concern:
  1. Line manager
  2. Designated person
  3. Higher level
  4. Regulatory organization / Helpline
  5. Externally
- Cast office
  - Care after death
- Fundamentals of Care:
  - Nutrition
  - Hydration
  - Bladder and bowel care
  - Physical handling
- Phases with wound healing:
  1. Hemostasis – 5 – 10 minutes (Vasoconstriction)
  2. Inflammatory – 1 – 5 days (clotting factors/histamine)
  3. Proliferation – 3 – 24 days (Granulation starts)
  4. Maturation – 21 days – 1 year (Re-epithelialization occurs granulation replaced by scar tissue)
- Wound Assessment
  - Tissue, Infection, Moisture Balance, Edge
- Types of Wound Healing
  1. Primary Intention – suture/skin adhesive
  2. Secondary Intention – boundaries cannot be brought together, made with contraction/epithelialization
  3. Tertiary Intention – healing delayed, wound left open then closed primarily after few days.
- DEPRESSION symptoms:
  - Behavioural
  - Physical
  - Cognitive
  - Emotional
- ZIMMER FRAME
  - Subtract 6 inches from patient height, affected leg first
- CANE
  - Cane with strong leg, cane advance with weak leg, strong leg with swing phase, bear down with cane

- Taking AMITRIPTYLINE, complains with symptoms of depression have not been resolved:
  - Re-assure patient that it will take 3-4 weeks to act
- Food rich in ANTIOXIDANT
  - Tomatoes, broccoli and carrot
- CVP measures
  - mean right atrial pressure
- Symptoms of PACE MAKER DISLODGEMENT:
  - Weakness
  - Dizziness
  - Easily gets fatigue
  - Loss of consciousness
  - Bradycardia
- Purpose of PROTECTED MEAL TIME
  - Provide an environment conducive to patients enjoying food
- NO vaccine administration to be delegated to a student in community set-up under direct observation.
- ENTONOX – should be inhaled in 1-2 minutes
  - Not an absolute contraindication to use for 1st to 16 weeks pregnancy and breastfeeding women (*No published material shows that nitrous oxide is toxic to the human fetus)
  - Daily use of Entonox for more than 4 days should be accompanied by CLOSE SUPERVISION and HEMATOLOGICAL MONITORING (check changes in red & white cells)
- 30mg/kg is the total dose. Weight is 48kgs. What is the single dose?
  - 1440mg or 1.4g
- Characteristics of TRANSFORMATIONAL LEADER
  - Domain 4-5 Leadership
- Patient BMI 28kg/m^2 = 25-29.99 OVERWEIGHT
- Best description for ENTERIC COATED TABLETS
  - Inner added to oral medications that allows the medication to pass through the stomach and be absorbed in the intestinal tract
  - e.g. ASPIRIN
- MINOR DISORDERS in PREGNANCY
  - Backache
  - Bleeding
  - Constipation
  - Cramps
  - DVT
  - Faintness
  - Headache
  - Incontinence
  - Tiredness
  - Pelvic pain
- Causes of CONSTIPATION in ELDERLY:
  - Low fiber diet
  - Low fluid intake
  - Lack of exercise
  - Emotional stress
- Accountable for RN actions
  - Him/Herself

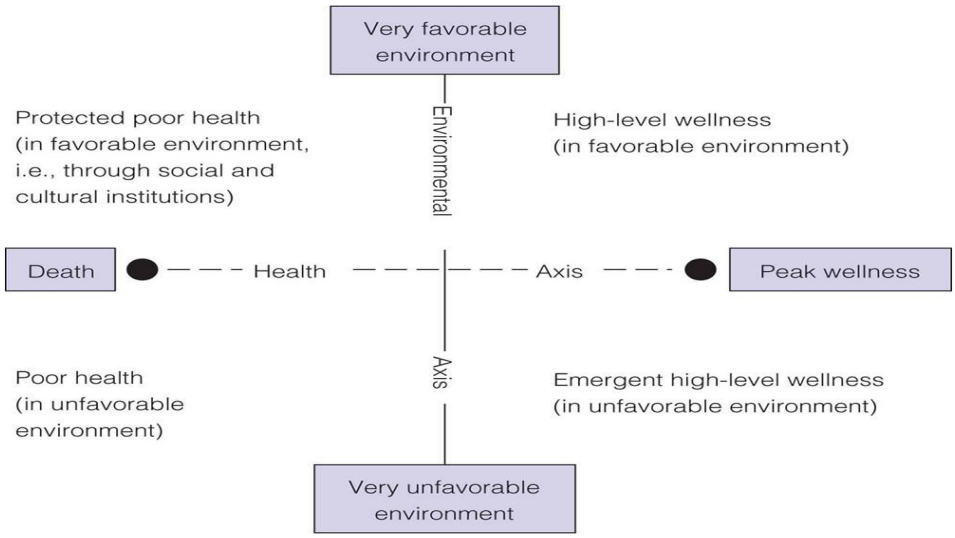
- When is voluntary advocate needed for a patient?
  - Access information and services, be involved in decision making, explore choices and options, defend and promote rights and responsibility.
- COLLUSION
  - Hiding information from patient as requested by the relatives
- RADIANT TREATMENT: SKIN CARE
  - Soap and water then keep dry
- CONVERT DRUG ADMINISTRATION
  - Only necessary or appropriate when individuals actively refuse medications and the one judged no to have capacity to understand the consequences of their refusal
- Breastfeeding helps to prevent infection
- STILL & NOT CRYING – response of a new born baby
  - Notify the hospital
- SALINE
  - Dressing solution that is less damaging
- LEVOTHYROXINE – for HYPOTHYROIDISM
  - 30mins to 1hr before breakfast
- Transcribing medicines followed by signing with registered prescriber
- Which action by the RN stops her to keep professional boundaries between RN and the client?
  - Focusing on social relationship outside work
- A patient with learning disability is accompanied by a VOLUNTARY INDEPENDENT MENTAL CAPACITY ADVOCATE (IMCA), what is her/his role?
  - An expert that represents client's concerns, wishes and views not expressed by themselves
- CONTINGENCY THEORY
  - Leader sees the kind of situation, the setting and their roles
- HASHIMOTO's Syndrome, Not a definition of:
  - blood and mucus in the stool
- Areas to consider when making decisions on Safeguarding:
  - WHO, WHAT, WHEN
- LEFT SIDED HEART FAILURE
  - Inspiratory crackles in lung bases
- CARE CORE PLAN
  - Smoking cessation nurse used this to communicate to and involve the patient in this case
- Normal Heart rate for 1-2 years old
  - 80-130bpm
- MILIEU ENVIRONMENT
  - Fostering or therapeutic, social, cultural and physical environment
- SEVERE BLEEDING
  - Moist skin and bluish nail beds
- PROPER URINE COLLECTION
  - Clean meatus with soap and water
  - Catch midstream
  - Dispatch sample to laboratory immediately within 24hrs
  - Ask the patient to void her remaining urine in the bedpan
- Disclosure (According to NHS)
  - Divulging/provision which occurs to date

- On walking with walking aid, move affected leg first on ascending stairs, go up with the good leg and come down with the bad leg.
- SUPPORTIVE COMMUNICATION
  - Face-to-face process of interacting that focuses on advancing the physical and emotional well being of the patient.
- Reablement/Enablement lasts for 6 weeks before further evaluation
- CCULTURATION (Concept)
  - Group that shares the same characteristics with a larger group in which it is part of.
- RIGHT SIDE LYING
  - After Liver biopsy
- EQUALITY ACT
  - Communication aid to the patient with disability
- FALSE statement about ABUSE
  - Can happen anywhere there is vulnerable adult
- Inadequate post-operative management
  - Physiological, behavioral, psychological: the RN must be alert for respiratory, cardiovascular and endocrine complications
- MENINGITIS
  - Complication specific to intrathecal/epidural analgesia
- RESPIRATORY ACIDOSIS
  - Dr. prescribe Bronchodilator
- Patient HYPERVENTILATING – RN intervention to decrease the risk of respiratory alkalosis
  - Teach the patient to do deep breathing techniques
- Patient on Lasix daily with IV fluid incorporated with 20mg KCl. What is the most important assessment to RN?
  - INTAKE and OUTPUT, because Hyperkalemia can occur rapidly
- MUSCLE WEAKNESS – Indicates Hyperkalemia
  - Use K-sparing diuretics
- Fine, Silky hair (Hyperthyroidism)
  - not to aging process
- Older adult with LORY, TORTUROUS, YELLOW NAILS
  - Refer to Chiropodist
- HANDS CLUBBING
  - Long term Oxygen deficit
- Geriatric ward – patients greatest risk for skin breakdown?
  - Patient who is incontinent of feces
- PRESSURE ULCERS
  - Type of wound that will heal by secondary intention (because it doesn't have approximate wound edges)
- Inflammatory response progressed to infectious process?
  - Yellow discharge (Infection process: purulent drainage, yellow, green, tan or brown)
- Wound irrigation: Sterile technique given by an RN?
  - Dried the skin or either side of the wound using one gauze pad each swipe (prevents cross contamination)
- Older adult with skin tear on the forearm. What type of wound dressing to use?
  - Transparent film dressing (have adhesive side that adheres to dry tissue but not moist tissue)

- Patient with abdominal wound with Vacuum-assisted closure device. What should the tissue viability RN do when applying this device?
    - Apply the transparent film 2 inches beyond the wound margins
    - Correct way to apply VAC device, this ensure that the transparent film has a firm seal around the wound.
    - Wound which is VAC therapy suitable:
        - ✓ Acute trauma – upper/lower limb burns
        - ✓ Chronic – pressure sores, leg ulcers, diabetic ulcers
        - ✓ Salvage – wound dehiscence, wound infection, post-op sternum infections
        - ✓ Surgical – skin grafts, flap surgery, wound bed preparation
- Patient referred for BP anticipated reading if he has high diastolic pressure: 130/95 mmHg
    - According to WHO: High systolic: 160mmHg and above
      High diastolic: 95mmHg and above
- Complications of uncontrolled Hypertension, EXCEPT:
    - CVA, Renal injury, Cardiac Hypertrophy, Anemia
- Serum level with Epinephrine increases body temperature by?
    - Increasing heat production
    - Epinephrine causes vasoconstriction that stimulates g & increases metabolic rate thus increasing heat production
- Patient with Pyrexia: Ritual RN intervention?
    - Direct fan therapy
    - Nursing Interventions for Pyrexia:
        - ✓ Prescribe antipyretics
        - ✓ Indirect fan therapy
    - Direct fan therapy and TSB should not be used while patient temperature is still rising as this will only make the patient colder and could cause distress
- Most notable physiological changes seen in Hyperthermia?
    - Vasoconstriction, shivering, increased carbon dioxide excretion
- GRADES OF PYREXIA
    - Low Grade – Normal to 38C (mild infection, allergy, surgery, malignancy)
    - Moderate to High – 38-40C (wound infection or UTI)
    - Hyperpyrexia – 40C above (bacteremia)
- HYPOTHERMIA – Acidosis can develop
- Elderly patient with moderate hyperthermia, RN action?
    - Program reheating device to register the temperature to increase 0.5-1 degree per hour
    - Rewarming should not be faster than 0.5C to avoid localized temperature differences
- FUROSEMIDE IV administration rate should not exceed 4mg/min
- Normal O2 Saturation: 95-100% or 96-100%
    - If at risk for Hypercapneic Respiratory Failure (COPD) – 88-92%
- When to consider clean gloves acceptable method for preventing infection?
    - When assessing IV insertion site

STERILE GLOVES	NON-STERILE GLOVES
- Surgical procedures - Invasive procedures - Aseptic techniques - Insertion of invasive devices (Urinary catheter, Central Venous catheter)	- Non sterile procedures (Patient exam) - Communal care equipment - Environmental cleaning - Minor skin surgery - Insertion with peripheral venous catheter, obtaining blood cultures or when a safety device or technique is used - When administering immunizations

- Which statement is not pertinent to NEWS?
  - Patient admitted to the theatre, surgical or step down ward may have their O2 saturation measured as routine every 12hours
- Dorothea Orem Theory
  - Promotes Nursing care that increases the patient self care ability
- Nursing action associated with FAYE GLEN ABDELLAH'S patient-centered approach?
  - The RN collects all data about the patient & organizes into an overt and covert problems as addressing the covert problems may solve the overt problems as well
- VIRGINIA HENDERSON'S Principles and Practice of Nursing?
  - "I am your Nurse for the next hours. You can use your call bell to page me when you need assistance."
- Nurse prioritizes needs based on Roper-Logan Tierney Model
  - Seek an order for Oxygen via nasal cannula
- Based on Gordon's Functional Health Patterns?
  - Health perception – health management pattern
- Accurate in relation to the concept of health and wellness indicated in presented theoretical framework
  - Facilitates prediction of whether the patient will likely improve in health or expect a decline based on level of support
- High Level Wellness Grid



- Statement by the patient, which indicates the conflict with ego, integrity vs despair, according to the Erik Erickson's Theory with development?
    - "I hope in my next lifetime I get a chance to become a doctor."
    - INTEGRITY VS DESPAIR is a task with older adult. The person reviews life experiences & is either encouraged and views life as meaningful or has sense of loss and regret.
      Non-achievement of goal – regret
- RN is evaluating patient outcomes associated with learning about HPN and self care. Which outcome?
    - Patient is able to assess that his/her BP is within the Normal limit after accurately obtaining BP reading using a sphygmomanometer
- SOCIAL LEARNING THEORY by Albert Bandura
    - Observational learning on modeling
- Statement by a Nurse Coordinator at a staff meeting exemplifies major focus with leadership?
    - "I know from your past performance with other procedures that you have the expertise to implement this new procedure."
- TRANSFORMATIONAL LEADERSHIP
    - Empowering and inspiring others y recognizing and respecting their knowledge and abilities
- Example of an INDEPENDENT Nursing Intervention
    - Delegating the giving of bath to an unregistered practitioner
    - 5 RIGHTS OF DELEGATION
        - ✓ Task
        - ✓ Circumstances
        - ✓ Person
        - ✓ Direction/Communication
        - ✓ Supervision
- SUPPLEMENTARY PRESCRIBING
    - A voluntary partnership between an independent prescriber and a supplementary prescriber to implement an agreed and specific clinical management plan with the patient agreement
- RN capacity under patient group situations?
    - Supply or administer any Sched 3 or 4 controlled srug in accordance with a PGD except anabolic steroids in part 4 with Sched 4 and major preparation with treating a person who is addicted to the drug
- Nurse Manager identifies Staff Nurse is in need of additional in-service education if:
    - The Staff RN assigns N.A. to monitor the VS and RN determine those that are significant
- RN is responsible to meet and discuss with a confirmation the requirement before?
    - 12 months before annual date
- Statement associated with Nursing Care Delivery Model?
    - Nurse Manager is responsible for ensuring that comprehensive care is delivered to all patients by all team members

20 CRITICAL QUESTIONS

-highly important, should be 90% above or with 18points correct answer (calculations, devices, safety, assessment, legal & ethics, skills & diagnostics)

- 4 MAIN ETHICAL PRINCIPLES OF NURSING PRACTICE
  - Autonomy – informed consent
  - Beneficence – benefits the patient
  - Non-Maleficence – avoid harm
  - Justice – Fair benefits
- Administering a new medication and the patient (alert & oriented) says she haven't seen that medication before. What follow-up action should the RN do?
  - First & foremost: Think about SAFETY
- Basics in Medication Administration:
  - Have a complete order
  - Check allergies (e.g. latex, food, contrast medications)
  - Assessment first – implementation later
    Notify MD & clarify is there is questionable order
  - 6 R's – calculate dose correctly
    - Patient
    - Dose
    - Medication
    - Time
    - Route
    - Documentation
- VIBRIO CHLERAE – severe Diarrhea
  CORYNEBACTERIUM DIPHTHERIAE – respiratory
  HELICOBACTER PYLORI – Gastric Ulcer
  STREPTOCOCCUS PNEUMONIAE – respiratory (pneumonia)
- HYPOTENSION and TACHYCARDIA – Initial signs of SHOCK
- Communicating to patient with DELIRIUM
  - Simple information in short sentences
  - Use close-ended questions
- Factors best improve communication between patient & RN
  - RN actively listening to the patient
- Non-Verbal Communication:
  - Square – face squarely
  - Open – open posture
  - Lean – lean forward when person is talking
  - Eye contact – good eye contact
  - Relax – stay calm & focused
- SUPPORTING COMMUNICATION FOR PERSON WITH DEMENTIA
  - Orient the patient and if necessary reinforcing this throughout the care intervention (constant reorientation)
  - Use short sentences, avoid providing too many choices
  - Close-ended questions
- PARACENTESIS POSITION
  - The bed is flat, head is slightly elevated
- Signs to watch out for Lumbar Puncture
  - Headache, back discomfort or pain, bleeding, brainstem herniation

- Chest Tube Thoracostomy (CTT)
    - For Pneumothorax, pleural collection, malignant effusions
    - Drainage: expiratory positive (+) pressure from the patient such as air and fluid out of the chest, gravity helps drain the fluid (placed below the patient chest)
- Nursing Process – cyclical, ongoing
    - Assess
    - Diagnose
    - Outcome Identification
    - Plan
    - Implement
    - Rationale
    - Evaluate
- Patient with HEAD INJURY
    - Cold compress to head
    - Seek medication advise if dizziness gets worse
    - Take Paracetamol for mild headache
    - GCS – 13 above – minor head injury
    - GCS 9-12 – moderate
    - GCS 8 below – severe
- Signs and Symptoms of ECTOPIC PREGNANCY
    - Symptoms develop at 4^{th} & 12^{th} weeks of pregnancy
    - Abdominal pain lowdown on one side (sharp, sudden, intense)
    - Pain at the tip of the shoulder
    - Vaginal bleeding
- Dehydration Signs & Symptoms in ELDERLY
    - Dryness on mouth, lips, tongue
    - Dry inelastic skin
    - .
    - dark strong smelling urine
    - sunken eyes
    - drowsiness
    - confusion
    - dizziness
    - low BP
    - low urine output
- Signs of MECONIUM ASPIRATION
    - Amniotic fluid has greenish color
    - Limp/inactive baby at birth
    - Over distended chest
    - Respiratory distress
    - Low heart rate
    - Low APGAR score
    - Cyanotic

IV DRUG CALCULATIONS

- $\frac{\text{Desired}}{\text{Stock}}$ x Quantity / Volume

- $\frac{\text{volume (ml) x gtts/min}}{\text{time (hr) x 60 mins}}$

- Macro = adult 20gtts/min
  Micro = Pedia 60gtts/min

- 1 g = 1000mg
  1mg = 1000mcg/ug
  1mcg = 1000nanogram

ROYAL MARSDEN STUDENT EXERCISES

INFECTION CONTROL

1. **STANDARD PRECAUTIONS**
   Using appropriate hand hygiene, wearing gloves & aprons when necessary, disposing the used sharps safely & providing care in a suitably clean environment to protect yourself and the patient.
2. **PATIENT IN SOURCE ISOLATION**
   Nurse with patient in isolation; ensure that you wear appropriate PPE for the purpose of preventing the spread of organisms from the patient to the others
3. **PATIENT HAD UTI**
   Increase temperature, raised white cell count, has new onset confusion & the urine in his catheter bag is cloudy
4. **CLOSTRIDIUM DIFFICILE**
   Action to prevent spread the infection
   - Review antimicrobials daily, wash hands with soap and water before and after each contact with the patient, ask for enhanced cleaning with chlorine based products & use gloves & aprons when disposing body fluids
5. **RN sustained NEEDLE STICK INJURY**
   Make the wound bleed, place under running water & wash thoroughly with soap & water. Incident form & inform manager. Test yourself and the patient for infection with blood borne virus, etc.

RISK MANAGEMENT

1. RISKS
   - Reduce from the healthcare setting
   - By adopting a culture of openness & transparency and exploring the root cause of the patient safety incident
2. PATIENT KNOCKS THEIR HEAD ON THE BEDSIDE LOCKER
   - Help patient in a safe comfortable position, take a set of observations and report the incident to the nurse in charge who may call a doctor.
   - Complete incident report form.
   - Discuss the incident with the patient if they wish, their relative.
3. 75 y.o. woman with abdominal hysterectomy 2 days ago
   To reduce risk of developing DVT?
   - Give adequate analgesia
   - Give subcutaneous low molecular heparin as prescribed,
   - Make sure she is wearing anti-embolic stockings
4. 80 y.o. man, with acute exacerbation with COPD. Shortness of breath, difficult to mobilize. To prevent pressure Ulcers?
   - Assess his risk with developing bedsores.
   - Process an appropriate pressure-relieving mattress for his bed and cushion for his hair.
   - Reassess the pressure areas at lest BID & keep them clean & dry
   - Review fluid & nutritional intake & support him to make changes as indicated

5. 76 y.o. woman, had numbers of falls at home. ENSURE SAFETY in the hospital, How?
    - make sure the bed is free of clutter
    - can reach everything she needs
    - assistance going to the toilet
    - ensure fitting slippers & walking aids

COMMUNICATION

1. FACTORS – SUPPORTIVE COMMUNICATION
    - Listening, clarifying concerns & feelings of the patient using open-ended questions
2. BEHAVIORS, Encourage patient to talk about their concerns
    - Tell patient that you are interested in what is concerning them & that you are available to listen
3. DENIAL VS COLLUSION
4. 3 ASPECTS OF ANXIETY
    - Physical – bodily sensation (fight or flight)
    - Behavioral – e.g. avoiding the situation
    - Cognitive – (thinking) e.g. imagining the worse
5. Patient with DELIRIUM: COMMUNICATION PRINCIPLES
    - Short statements & closed questions
    - Well-lit, quiet, familiar environment

ELIMINATION

1. Penile sheath as means of managing incontinence
    - When other methods of continence management has failed
2. Correct size of catheter: Most important GUIDING Principle
    - Smallest size necessary
3. Male and Female patient require anesthetic lubricating gel prior to catheterization
4. On removing patient catheter:
    - Encourage your patient to exercise and drink 2-3L of fluid per day
5. Positioning Urine drainage bag
    - Below the level of the bladder to reduce backflow of urine
6. IATROGENIC CONSTIPATION
    - Antiemetic or opioid medication
7. DIARRHEA INITIAL MANAGEMENT
    - Assessment
    - Source isolation
    - Universal precaution
8. LOOP COLOSTOMY: CONSIDERATIONS IN SELECTING APPROPRIATE STOMA
    - Cognitive ability, lifestyle, patient dexterity, position of stoma, state of peristomal skin, type of stoma, consistency of effluent, patient preferences
9. NEWLY FORMED STOMA: DIET
    - Encourage a varied diet
10. PROVIDING STOMA EDUCATION, PREPARING PATIENT FOR DISCHARGE: MAIN OBJECTIVE:
    - Patient can independently manage their stoma & can get supplies

MOVING AND POSITIONING

1. Skeleton – structural framework
   Muscle – moves with skeleton (contracts, extends)
   - cross at least one joint & they are attached to the skeleton
2. MOST COMMON EFFECTS OF INACTIVITY
   - Social isolation
   - Loss of strength of muscles
   - Pulmonary embolism
   - Loss of independence
   - High risk of chest infection
3. HELPING PATIENT WITH SHORTNESS WITH BREATH SIT OUT IN A CHAIR
   - Orthopnea position: sit in a forward leaning position supported by pillows, needs access to a nebulizer & humidified oxygen
4. BRONCHITIS: POSITION THAT WOULD HELP DRAIN THE SECRETIONS
   - Lying on his side with the area to be drained uppermost after the patient has humidified oxygen
5. CVA (Cerebrovascular Accident), left leg has increased in tone, very stiff and difficult to position comfortable
   - Try to diminish increased tone by avoiding extra stimulation
   - Supporting pillow, left leg in side lying & keeping the knee fixed

NUTRITION, FLUID BALANCE, BLOOD TRANSFUSION

1. IV – "positive fluid balance"
   - Fluid input that exceeded the output
2. ENTERAL FEEDING: Monitor to avoid complications & ensure optimal nutritional status
   - Blood glucose levels, full blood count, stoma site & body weight
3. Patient needs to be weighed: experience a lot of pain on movement
   - Offer the patient pain reliever and use either bed scales or hoist with scales built in
4. Sip feeds
   - Type of feeding which sill provide all protein, vitamins, minerals & trace elements to meet a patient's nutritional requirements
5. Patient for nutritional support and receives HYPEROSMOLAR feeding. He presents with diarrhea but has no pyrexia. What is the cause?
   - The feeding
6. Patient with esophageal tumor waiting for surgery. Most likely route to provide him with nutritional support he needs?
   - Feeding via RIG (RADIOLOGICALLY INSERTED GASTROSTOMY)
7. ENTERAL FEEDING: Prevent aspiration by?
   - Sit them at least 45^{o} angle
8. Medications safe via NGT
   - Drugs that can be absorbed via this route can be crushed & given diluted or dissolved in 10-15ml of water
9. Before enteral feeding via NGT: Check
   - pH of gastric aspirate is <5.5 & the measurement on the NG tube is the same length as the time of insertion
10. Blood trasnfusion

- Temperature, Pulse rate, BP & Respiratory rate before BT begins & after 15 minutes, then as indicated in local guidelines & finally at the end of the bag/unit.

PATIENT COMFORT

1. Extra care when washing & drying elderly patient's skin?
   - Reduced blood supply, thinner, less elastic and has less natural oil, less resistant to shearing forces & wound healing can be delayed
2. Patient with DM & PERIPHERAL NEUROPATHY: Cutting Toe Nails
   - Document clearly the reason for not cutting his toe nails & refer him to a CHIROPODIST
3. Patient is agitated & unable to settle, difficulty sleeping & in pain
   - Ask her to score her pain, describe its intensity, duration, the site, any relieving measures & what makes it worse, looks for non-verbal cues so as to determine the appropriate pain management method
4. WHO ANALGESIC LADDER: Tramadol & Codeine
   - Step 2: Opioids for mild to moderate pain
5. BREAKTHROUGH PAIN: Type of prescription?
   - Adequately controlled pain relief with short-lived exacerbation to pain. Prescription has no regular time with administration with analgesia
6. Patient was returned from OR (Left arm surgery) has PCA infusion connected & from admission you remember that he has POOR DEXTERITY on the right hand. Patient is pain free.
   - Contact the Pain team/anesthetist to discuss the situation & suggest that the means of delivery are changed
7. ENTONOX/NITROUS OXIDE can be considered
   - Wound dressing change for short term pain relief of the removal of a chest drain for reduction of anxiety
8. Patient received opioids frequently: key Nursing observations
   - Respiratory rate, bowel movement record, pain assessment score

RESPIRATORY CARE

1. Respiratory Status: Initial Assessment
   - Observe the patient breathing for ease and comfort, rate & pattern
2. Prescription for Oxygen therapy includes
   - Type of oxygen delivery system, inspired oxygen percentage & duration of the therapy
3. SUCTION
   - Never insert the catheter for longer than 10-15 seconds
4. COPD patient requiring 70% oxygen via facemask. Patient with oxygen saturation of 95-98%. MD has been taking ABG.
   - It measures both Oxygen and Carbon Dioxide level & therefore can give indication with both ventilation & oxygenation
5. NASAL CANNULA: Maximum Oxygen flow rate 6Lpm. Why?
   - Higher rates can cause mucosal drying & may lead to epistaxis
6. ER – patient for VENTRICULAR FIBRILLATION
   - Early defibrillation to start the heart
7. Humidify oxygen used during respiratory therapy: reason?

- Oxygen is a dry gas which can cause evaporation with water from respiratory tract & lead to thickened mucus in the airways, decrease movement of cilia and increase susceptibility to respiratory infection

DIAGNOSTICS

1. Specimen had a biohazard sticker
   - Double bag it in an self sealing bag & wear gloves when handling the specimen
2. Venepuncture: best way to avoid hematoma forming
   - Choose a soft, bouncy vein that refills when depressed and is easily detected. Advice the patient to keep his arm straight whilst firm pressure is applied
3. ADULT patient BLOOD CULTURE ratio
   - Collect at least 10ml of blood
4. Blood for another test & blood culture, to decrease the risk of contamination:
   - Inoculate the aerobic culture first
5. Infection
   - Temp: 38.5C, shivering, tachycardia, hypertension
6. Techniques for Urine specimen
7. Patient DYSPHAGIA
   - Gastroscopy
8. Patient have PACEMAKER in SITU
   - No to imaging except MRI
9. Patient CRAMPING SENSATION in their ABDOMEN after colonoscopy
   - Eat & drink as soon as sedation has worn off
10. Potential complications related to LIVER BIOPSY
    - Inadvertent puncture with the pleura, a blood vessel or bile duct

OBSERVATIONS

1. Adult patient in acute hospital setting, observations taken when?
   - When they are admitted & initially assessed. A plan should be clearly documented which identifies which observations should be taken and how frequently subsequent observations should be done.
2. PHYSIOLOGICAL SCORING SYSTEM or EARLY WARNING SCORING
   - Provides early accurate predictor with deterioration by identifying physiological criteria that alert the Nursing staff to a patient at risk
3. Patient complains, "heart is racing". Pulse is too fast to manually palpate. Actions?
   - Full set of observations: BP, RR, O2 sat, temp. Essential to perform 12 lead ECG, the patient should be reviewed by the MD
4. Orthostatic BP measurement be indicated
   - Patient has a history of dizziness or syncope or changing position
5. Adverse effects of hypotension
   - Decreased consciousness level, oliguria, decreased coronary blood flow
6. CONTRAINDICATIONS for use of BLOOD GLUCOSE METER for blood glucose monitoring.

- If peripheral circulation is impaired, collection of capillary blood is not advised as the results might not be a true reflection of the physiological blood glucose level

7. Patient had recent head injury – RN every 15minutes NEUROLOGICAL OBSERVATIONS, Pupil unequal & one is not reactive to light, unable to arouse patient. Action?
    - Medical emergency. Basic airway, breathing & circulation should be attended urgently & senior help should be sought
8. Accurate method in calculating Respiratory Rate
    - In 1 full minute, one cycle= patient's chest complete rise and fall
9. 17y.o. with acute exacerbation with asthma. Peak flow readings are deteriorating & she is becoming wheezy. Action?
    - O2 saturation & RR. Administer humidified O2, Bronchodilator, corticosteroids & antimicrobial therapy as prescribed

MEDICINE MANAGEMENT

1. Professional responsibilities of the qualified nurse in the medicine management
    - Safe handling & administration of all medications to the patient in their care.
    - Includes: making sure that the patient understand the medication they are taking, reason they are taking & the likely side effects
2. Key Reasons for administering medications to patient
    - As part of a process in diagnosing their illness, to prevent an illness, disease or side effect, to offer relief from symptoms or to treat a disease.
3. Most common type of Medication Error
    - Administration with the wrong drug, in the wrong amount to the wrong patient via the wrong route
4. Patient collapsed with an anaphylactic reaction. Symptoms?
    - Patient will quickly find breathing because of compromised airway or circulation. Accompanied by skin & mucosal changes
5. Potential benefits of Self-Administration of medicines
    - Gives patient more control
    - Allows patient to take medication on time
    - Gives patient opportunity to address any concerns with their medications before they are discharged home
6. Checking the stock balance in the controlled drug record book, You & colleague notice a discrepancy. Actions?
    - Check the cupboard, record book & order book & inform the RN or person in charge with the clinical area. If the missing drugs are not found, then inform the most senior nurse on duty. You will also complete an incident form.
7. Patient is on regular oral morphine Sulfate. Qualified RN Legal checks:
    - Check the stocks & oral Morphine SO4 in the CD cupboard with another RN then in the control drug book. Together, check the correct prescription & identify the patient
8. Vomits after Tablets
    - Check to see if the patient has vomited with tablets
    - Document this on the prescription chart

- Drugs may be given again after the administration with antiemetic or when the patient no longer feels nauseous
- Discuss an alternative route of administration with the MD

9. IV ROUTE
    - Provides immediate therapeutic effect
    - Gives better control with the rate of administration as a more precise dose can be calculated
10. Patient mid-day oral METRONODAZOLE. You never met her before administration.
    - Check her name, date of birth, hospital number, any known allergies, prescription for metronidazole: dose, route, time, date, signed by the MD & when it was last given

PERIOPERATIVE CARE

1. Primary purpose of Modified Early Warning Score (MEWS)
    - Identifies patient at risk with deterioration
2. Fasting prior to surgery
    - To lower risk with reflux & inhalation with gastric contents
3. Gaining informed consent prior to planned surgery: Principles
    - Gaining permission from a patient who is competent to give it, providing information in understandable terms prior to surgery, allowing time for answering questions & inviting voluntary participation
4. Safe moving & handling: minimum number of staff required to provide safe manual handling of a patient in the theatre
    - 4 (1 each side, 1 at the head and 1 at the foot)
5. Anti-embolic stockings
    - Reduces potential of developing DVT by promoting venous blood flow
6. Post-operative patient, tachycardia, anxious with increased RR. Actions?
    - Symptoms of hypovolemic shock
    - Investigate source of fluid loss, administer fluid replacement & medical support

WOUND MANAGEMENT

1. Functions of dressing for effective wound healing
    - Increase humidity, insulation, gaseous exchange, absorbent
2. Wound Care Plan
    - On every ward
3. Chronic Wound
    - Debride & apply hydrogel dressing
4. New post-surgical wound is hot, tender and swollen
    - Inflammation phase with healing
5. Four Stages of Wound Healing in order
    - Hemostasis
    - Inflammation phase
    - Proliferation phase
    - Maturation phase
6. Elderly immobile patient with Grade 3 Pressure sore. Management?
    - Foam dressing, pressure-relieving mattress, nutritional support

- CONTROLLED DRUGS
  - Listed in Schedule 2 with the Misuse Drugs Act 1971
  - E.g. morphine, amphetamines, benzodiazepines
- MEDICINES ACT 1968
  - Set out the requirement for the legal sale, supply & administration with medicines
- MISUSE OF DRUGS ACT 1971
  - Controls the export, import, supply & possession of dangerous or otherwise harmful drugs
  - Controls the manufacture of controlled drugs
- SIDE EFFECTS OF OPIOIDS
  - Constipation – patient must be prescribed with laxatives
  - Nausea – antiemetic & must be given assurance
  - Vomiting
  - Drowsiness – reassure patient that it will subside after few days
- OPIOIDS TOXICITY (pg 696 Royal Marsden)
  - Pin-point pupils
  - Confusion
  - Hallucinations and nightmares
  - Myoclonus
  - Respiratory depression
    - NALOXONE – reverses the effects of opioids toxicity
- FLUNAXENIL
  - Reverse effects with BENZODIAZEPINES

- **REGARD ALL ITEMS AS CRITICAL QUESTIONS!!**

- MOSTELLAR FORMULA

$$\text{BSA} - \sqrt{\frac{\text{Ht (cm x Wt (kgs)}}{3600}} \quad \text{or} \quad \sqrt{\frac{\text{Ht(in) x Weight (lbs)}}{3131}}$$

  - Multiply the choices by itself to opt the square root
- ESCALATION
- PROLIFERATION
  - granulation phase
- Danger (survey the scene)
  Responsiveness
  Shout for help (call for help)
  Airway (look, listen & feel) 10 seconds= check for obstruction
  Breathing
  Circulation – (fast) 30:2 (deep: 5-6cm depth) using BVM
  Target 100-120bpm
- Assessment
  Planning – plan for NCP
  Intervention – implement the NCP
  Evaluation – Revision (organizing)
- CLOSTRIDIUM DIFFICILE
  - Caused by antibiotic therapy
  - Low immune system
  - Pseudomembranous Colitis
  - Do not let the patient take antibacterial medications

- Types of dressings
    - Alginate
    - Hydrocolloid
    - Hydrogel
    - Foam absorbent dressing
- Handwashing
    - Palm to feel
    - Palm to dorsum
    - Finger interlaced
    - Fingers interlock
    - Thumb
    - Fingertips
    - Wrist
    - Rinse UPWARD
- Alcohol rub
    - 20 seconds (3x)
- Hand washing
    - 60 seconds
- 5 moments of Hand washing
- TRIAD OF OPIOID TOXICITY
    - CNS depression
    - Respiratory depression
    - Pupillary miosis (constriction)
- Medulla oblongata
    - respiratory center
- Stomatitis
    - inflammation with the mouth and tongue
- Denture-related
    - palate & gums shine redness
- Gingival bleeding
    - poor removal of plaque
- First 24hours of bleeding
    - primary post partum hemorrhage

  More than 24hours until 12 weeks
    - secondary post partum hemorrhage
- Sharps
    - do not recap needles (use fishing techniques if needed)
- DOUBLE BAGGING increased temperature (Waste disposal)
- Tuckman's team formation
    - Forming – identifying members
    - Storming – discussing issues
    - Norming – solution
    - Performing
    - Adjourning – end session
- Kubler Ross
    - Denial, Anger, Bargaining, Depression, Acceptance

- Phlebitis
    - Pain (dolor)
    - Redness (rubor)
    - Immobility (loss of function)
    - Swelling
    - Heat (Kalor)
- Left Hemisphere
    - Aphasia
        - Apraxia – loss of capacity to do complex movement
- Losing a life partner
    - Uncoping ability
    - All normal signs and symptoms
    - Normal part of grieving
- Hypodermic needle
    - 90 degrees
        - Subcutaneous – 45 degrees
- Abdominal aortic aneurism
    - Most common aneurysm for elderly
- Abdominal tap/paracentesis
    - Supine with head of bed elevated at 40-50cm
        - If little amount to be taken- sitting position
- Orthopneic position
    - For patient with shortness of breath
- Low BP in elderly
    - Low response in adrenaline & noradrenaline
- Best way to verify enteral tube prior to feeding
    - Aspirate gastric content
    - pH <5.5
- Lumbar tap
    - Brain herniation – increased HR
    - Foramen magnum – Low BP, change in consciousness
    - Spinal cord – 45cm
- Informed consent: rules
    - Witness & client advocate
- Heart rate
    - Infants – 120-160
    - 2y.o. - 70-110
    - 24 y.o. below – 80-150
    - Adult – 60-100
- Allopurinol
    - Do not let the patient chew the medications (enteric coated)

NURSING DOMAINS IN CBT

DOMAIN 1: PROFESSIONAL VALUES

- All new nurses must act to care & safeguard the public
- Safe, compassionate, person-centered, evidenced based nursing that respects dignity & human rights
- Show professionalism & integrity & work within professional, ethical & legal framework
- Work with other professional agencies ensuring shared decisions on care of the client
- Patient HIV (+) – she told you:
    - Educate the patient to divulge the information for better Nursing care.
    - Tell the members of the healthcare team handling the patient directly
- Chinese patient- doesn't want the TAB because he/she believes it has animal content:
    - Omit the dose & document
- Carer's assessment
    - Is the carer are capable to provide care for the patient
- Do not stop if you are not competent enough
    - Inform the supervisor
- Do something to help/gain access/dial emergency hotlines
- Good leaders should give recognition
    - Fordoing good practice
- Notice the negative practice
- Know the boundaries of yourself as a Nurse

DOMAIN 2: COMMUNICATION AND INTERPERSONAL SKILLS

- Use communication & interpersonal skills; communication must always be safe, effective, compassionate & respectful
- Take into account individual differences
- Use range of communication skills to support person-centered care & enhance quality & safety
- Recognize when people are anxious or in distress & respond effectively
    - Raise safeguarding alert
    - Call professional translator always
    - Negotiation strategies- patient doesn't want fluids, the spouse is going to visit
        - Ask the patient's favorite drink
    - Disengage from professional caring relationship= DUTY OF CANDOR

DOMAIN 3: NSO PRACTICE AND DECISION MAKING

- Practice autonomously, compassionately, skillfully & safely
- Assess all range essential with physical & mental health needs of people in all ages
- Safe and effective immediate care to all people prior to accessing or referring to specialized services
- Based from the best available evidence
- Decision making must be served to service users, carers and families

- LONE NURSING – involve in policy making/formulation of community nursing
- Assessment- potential/actual problems
- Evaluation- decisions are made

DOMAIN4: LEADERSHIP, MANAGEMENT AND TEAM WORKING

- Nurses must be professionally accountable & use clinical governance processes to maintain & improve the nursing practice
- Respond autonomously & confidently to planned & uncertain situations
- Must create benchmarking

DOMAIN 5: ADULT NURSING

- Apply legislation to vulnerable people, geriatrics, mental health patients, etc
  Acute illness: 3-6months Chronic Illness: 6 months above
- Bulimia
- Anorexia
- Normal Blood Glucose in UK;
  - RBS: 4-8mmol
- After lumbar tap
  - 4° lying flat on bed (avoids CSF leakage)
- Post-operative: Main concern:
  - Pain
- Enteral feeding for patient with abdominal surgery
  - Sitting upright at 30-45° (low back), 45-60° (moderate)
- NPO= NBM in UK
  - NIL By Mouth
- For surgery
  - Prevention of aspiration
- Nocturia
  - Urinate at night
- Oliguria
  - <400-500ml
- Pyrexia is not evident in the elderly because?
  - Aged hypothalamus
- Crutches
  - Measurement: floor to axilla minus 2 inches
  - 3 patient gait- advance affected leg & crutch then advance the unaffected leg
- Chron's Disease
  - Inflammatory bowel disease, GI tract inflammation
- Ulcerative Colitis
  - Pathognomonic Sign: blood & mucus in the feces
  - Rectum & large intestine
- Digoxin/Lanoxin
  - Electrolyte imbalance in toxicity
  - Hypokalemia (most common)
  - Hypomagnesaemia
  - Hypercalcemia
  - Patient heart rate is 50bpm: omit next dose & document
    - Adult <60bpm Pedia <90bpm
- Not a classic sign of dehydration
  - Passing small amount of urine frequently (<3-4/days)

- Meconium Stain
  - Baby can't cry
  - Low heart beat
  - Rapid labored breathing
- CVA, if with DYSPHAGIA
  - Give thick fluid
- COPD
  - 1-2LPM of Oxygen, do not increase oxygen level, 88-92% O2 Sat
- Anaphylaxis
  - BP drops first then it will increase later on
- 3P's for FIRST AID
  - Preserve life
  - Prevent further injury
  - Promote recovery
- Universal precaution
  - Blood borne disease
- Speed Shock
  - Headache, irregular pulse, tight feeling in the chest, flushed face, decrease consciousness, cardiac arrest, EXCEPT cyanosis
- Low Pulse Rate
  - Early fluid volume deficit
- Patient with Increased ICP
  - Not an indication for lumbar tap (may cause seizure)
- Abdominal Paracentesis
  - Supine in bed, head raised 45-50cm with a back rest
- Clamping Chest Tube
  - Prevent further lung collapse & entry of air
- Not considered in an Oxygen prescription
  - Can be given to the patient who are not hypoxaemic
- Accountability
  - HCA (Hot sitz bath)
- Primary care
  - Day to day care given by the healthcare provider
- Does not cause postural hypotension
  - Lack of exercise (Risk factor only)
- Assessment
  - Does not include patient needs and concerns
- NOT expected side effect of Lumbar Tap
  - Nausea/Vomiting – because increased ICP (adverse effect)
- Aching muscles
  - Not a sign and symptom of infection
- Respiration
  - Transport of Oxygen from outside air to the cells within the tissues and CO2 in the opposite direction
  - Pulmonary Respiration – breathing
  - External Respiration – from the lungs into the blood (gaseous exchange)
  - Internal Respiration – blood to the cells
- WATERLOW CHART (Pressure Ulcers)
  - 10+ - Specialist memory foam (uratex type)
  - 15+ - Alternating overlay pressure mattress (egg crater)

- 20+ - Dynamic/Fluidized

- 5 portions of fruits & vegetables
  - Non-insulin dependent DM patient
- IDDM
  - It depends, no particular fruits/vegetables portion
- COPD patient ABG reading
  - Increase PCO2 and low PO2
- PRION
  - Creutz Feldt Jakobt Disease (Mad Cow Disease)
- Intraperitoneal Hemorrhage
  - Most definitive complication 24hrs after biopsy
- Infection
  - Not expected as complication for Lumbar Tap
- Suffering from dehydration, sign and symptoms
  - Passing of small amount of urine infrequently
- Flat low on bed
  - After lumbar puncture
- Patient with Crohn's Disease
  - Except strawberries and seeds
- Piles/Hemorrhoids
  - Not caused by prolonged walking (it relieves)
- Postural Hypertension
  - Does not apply: less exercise & activities

THE 6 C's

- Values based for leading change, adding value, framework for Nursing & midwifery and care staff

I. CARE

Core business, helps individual person & improves the health of the whole community, people needing care expect it to be right with consistency throughout every stage of their life

II. COMPASSION

Care is given based on empathy, respect & dignity, intelligent kindness, central to how people perceive their care

III. COMPETENCE

Ability to understand an individual's health & social needs. Expertise, clinical & technical knowledge to deliver effective care & treatment based on research & evidence

IV. COMMUNICATION

Central to successful caring relationship & to effective team work. Listening is important, essential for "NO DECISION ABOUT ME WITHOUT ME" – KEY to a good workplace with benefits for those in our care & staff alike

V. COURAGE

Do the right thing for the people we care for, to speak up when we have concerns. Personal strength & vision.

VI. COMMITMENT

Cornerstone of what we do. Build on our commitment to improve the care & experience of our patient. Take action to make this

vision & strategy a reality for all & meet the health & social care challenges ahead.

NHS CORE VALUES

I. COMMITMENT TO QUALITY OF CARE

Insisting, guiding or striving to get the basic right every time. Welcome Feedback Avenue for success – learn from mistakes & build on success

II. COMPASSION

Respond with humanity & kindness to each person's pain, distress, anxiety or need. Do not wait to be asked

III. EVERYONE COUNTS

Use our resources for the benefit of the whole community & make sure nobody is left behind.

IV. IMPROVING LIVES

Improve health, well-being and people experiences with NHS value, excellence & professionalism.

V. RESPECT DIGNITY

Value each person, respect their aspiration & commitments in life, honest about our point of views & what we can and cannot do.

VI. WORKING TOGETHER FOR THE PATIENT

Put patient first in everything.

STANDARDS FOR MEDICINES MANAGEMENT
SECTION 1

METHODS OF SUPPLY AND/OR ADMINISTRATION OF MEDICINES

1. PATIENT SPECIFIC DIRECTION (PSD)
   - Written instruction from a qualified & registered prescriber (specific direction)
2. MEDICINES ADMINISTRATION RECORD (MAR)
   - Not a prescription but a direction to administer medications
3. PATIENT GROUP DIRECTION (PGD)
   - Specific written instructions for the supply or administration of a licensed named medications including vaccines to specific groups of patient.
4. MEDICINES ACT EXCEMPTION
5. STANDING ORDER
   - Not a prerequisite under any legislation
6. HOMELY REMEDY PROTOCOL
   - Can't be used for
7. PRESCRIPTION FORMS
   - Serially numbered & have anti-counterfeiting & anti0forgery features (Secure stationary)
8. REMOTE PRESCRIPTION
   - Only medications which are previously prescribed, not applicable to new medications unless in life threatening situations

- 6 Rights

Time Dose
Patient Documentation
Route Drug

- Pharmacists transcribing term:
  - Transposing
- Prescription is
  - Valid for 3 months, others one month only
- MRN
  - Medical Record Number = Hospital Number

THE CODE

- Professional standards that registered nurses & midwives must uphold (leadership, education & research)
- Not negotiable or discretionary

1. **PRIORITIZE PEOPLE**
   - Care & safety of the patient is the main concern
2. **PRACTICE EFFECTIVELY**
   - Assess needs & deliver or advice on treatment or give help without too much delay to the best of your abilities
3. **PRESERVE SAFETY**
   - Duty of Condor
     - Say sorry
     - Escalate to GP & line manager
     - Proper documentation
     - Yellow card scheme
     - Monitor the patient
4. **PROMOTE PROFESSION & TRUST**
   - 450 prescribed hours
   - 35 CPD units
   - 3 years revalidation

- Independent Nurse Prescriber
  - Only training & requirements

INFECTION CONTROL

I. Standard Precaution
II. PPE
III. Safe Handling & disposal of sharps

REVALIDATION

- Maintain registration with NMC – responsibility of RN & RM
- You are the owner of your own revalidation process
- Does not determine if you are fit to practice
- Not a way to raise fitness to practice concerns
- Not the same as the requirement with the employees

REQUIREMENTS

1. PRACTICE HOURS
   - 450 hours required, not optional
2. CPD units
   - 35 hours of training to complete in a 3 year period
   - relevant to the scope of practice
   - at least 20 hours must have participatory learning
   - 15 hours theoretical
3. Practice related feedback
   - 5 pcs with practice related feedback in 3-year period
4. WRITTEN REFLECTIVE ACCOUNTS
   - 5 WRA
   - instance with your CPD
   - piece of practice related feedback
   - event or experience & how it related to the code
5. REFLECTIVE DISCUSSION
   - Discussion with another NMC registrant with WRA
6. HEALTH & CHARACTER
   - Declare if you have been convicted with any criminal offense
7. PROFESSIONAL INDEMNITY ARRANGEMENT
   - Insurance
8. CONFIRMATION
   - Declaration of being compliant with the revalidation process.
   - Made by somebody who is your head in the hospital/community

WALKERS

- Walking frame
  - Relieves pain & pressure from surgery (hips, knees & ankles)
  - Provides stability
  - Physiotherapist will determine
- To walk – small steps
- Stairs – Good first UP, Bad first DOWN
- Encourage patient to talk
  - Supportive communication, available to listen
- Anxiety: 3 main points to involve
  - Physical – fight or flight
  - Behavioral – avoid
  - Cognitive – imagining the worse
- Patient with DELIRIUM, Communicating RN:
  - Short statements, close ended questions, well lit, quiet & familiar environment
- Patient with Dementia
  - Constantly re-orient the patient & provide non-stimulating environment
- Abdominal Incision
  - 35-45 degrees
- Enteral feeding position
  - Sit at least 45 degrees, moderate high back
- Abdominal Xray
  - MOST RELIABLE method in testing the placement of enteral tube
    - If PRIOR to FEDDING: aspiration of gastric contents (acidic <5.5pH)

- Acute Traveller's Diarrhea: most common to?
  - Young adults
  - Rotavirus, E. coli
- Hypotension adverse effects
  - Decrease level of consciousness
  - Oliguria
  - Low coronary blood flow
- Patient in Protective Isolation what to drink?
  - Long life fruit juice & filtered water
- 80 y.o. patient with MRSA
  - sensory deprivation
- Daughter want to visit at the hospital but with vomiting & diarrhea
  - Wait for 48hrs symptom free before visiting
- First stage of wound healing
  - Hemostasis – 5-10 minutes only (clotting cascade then fibrin formation
- For effective wound healing, dressing should be?
  - High in humidity
  - Insulation
  - Gaseous exchange
  - Absorbent
- Patient with necrotic wound, type of dressing to be used?
  - Debride & apply hydrogel dressing (autolytic debridement, aided by the enzymes of the body)
- 4 stages of wound healing
  - Hemostasis – 4-5 minutes
  - Inflammatory – 1-5 days
  - Proliferative – 3-24 days
  - Maturation – 21 days to 1 year
- Pressure Sore
  - Grade 1 – blanching/blister
  - Grade 2 – epidermis / dermis
  - Grade 3 – fat, adipose tissue/subcutaneous
  - Grade 4 – muscles, bones, tendons
- Pack years
  - 20 manufactured cigarettes smoked per day in 1 year
- Chest Tube: fluctuation with fluid
  - Normal finding, continue to monitor
- ET tube, following radical neck dissection, RN reports immediately?
  - STRIDOR – indicate airway obstruction or airway edema
- Yellow Card Scheme, all is included, EXCEPT:
  - All adverse reaction
  - Electronic cigarettes
  - Defects in medical devices
  - **None of the above**
- Hispanic Client – **all of the above**
  - Includes Hispanic members with the healthcare team
  - Interpreter
  - Education (written in Spanish)
  - Speaking in normal tone

- Grieving because of losing life partner
  - Normal 6 weeks minimum
- 8 y.o. patient
  - talk to the patient using age specific approach
- Subcutaneous Insulin injection
  - 90° angle (45-90°)
- Least thing suitable to be sent via email
  - Any abnormal laboratory results
- NGT insertion
  - Measure from the tip of the earlobe to the bridge of the nose down to the xiphoid process
- Controlled drugs at home
  - CD must be locked inside the cupboard
- Patient brought hos own medications. What should NOT be done?
  - Ask the companion to take the medication at home
- On removing patient catheter, encourage patient to:
  - Exercise/ambulate & drink 2-3L of fluid everyday
- Principles of positioning the urine bag
  - Below the level of the bladder
- Your colleague prepares the medications but asked you to give them, what to do?
  - Never give the medication
- Drug chart
- Medications
  - Prevent disease/side effect, relief of symptoms or to treat a disease
- Common type of medical error
  - Wrong drug, wrong amount, wrong route, wrong patient
- SPO2
  - 96-100% or 95-100%
- RN and Nursing student may jeopardize their nursing in relation to social media, except:
  - Sharing confidential people appropriately
- Legal checks you need in Morphine Sulfate
  - Stock with oral Morphine in the CD cupboard with another RN & document this in the control drug book, together check the correct prescription & identify the patient
- Creutzfeldt-Jakob disease
  - Rare, degenerative, invariably fatal brain disorder
  - 1/million people is affected per year in the world
  - Caused by abnormal infection called PRIONS
  - Destroys brain overtime
  - Death is experienced 8 months after symptoms appear
  - Signs & symptoms
    - Mental deterioration
    - Involuntary movement
    - Blindness
    - Weakness of extremities
    - Coma
    - Fever & flu like symptoms

- MRSA
  - Gram (+) bacterium that is genetically different from other strains of Staphylococcus Aureus
  - Cannot be cured by beta-lactam antibiotics (Penicillin)
  - Can be acquired though open wounds & catheters
  - Signs & symptoms:
    - Small red bumps that enlarge & become painful
    - Fever
    - Occasionally rashes
- Obesity is the high in lower socio-economic sector, cause?
  - Socio-inequality
- Post Lumbar punctures, patient experiences dizziness, shortness of breath & loss of consciousness:
  - BRAIN HERNIATION
- DIGOXIN will have an interaction with all of the following, EXCEPT:
  - NSAIDS
- NMC is best defined as
  - Responsible for RN & RM standards with ethics, conducts & performance
- Post Lumbar, how to position the patient? Place patient for 4hrs flat on bed:
  - Let the patient assist him/herself holding on the side of the bed to supine position
- How to instruct a patient to use Zimmer's frame?
  - Lift frame then place one step ahead
  - Push frame in front & hop unaffected leg to the frame
- THIRST
  - MOST COMMON EARLY sign of dehydration, another is dark colored urine
- Untreated Dehydration, VS:
  - Low BP, Increased Pulse rate
- MUST: Medium risk intervention?
  - Assess dietary intake of the patient for the past 3 days
- Breach to a patient's dignity & privacy
  - Drawing curtains in a general ward
- Care package during discharge, conduct?
  - Carer's assessment
- Corticosteroid
  - Muscle weakness
  - Moon face
  - High BP & weight
  - Mood changes
  - Delayed wound healing
- Most common cause of falls among elderly?
  - Beta-blockers, Diuretics

- Dorothea Orem- self care deficit, soundness & wholeness of developmental human structure & bodily mental functioning
  Imogene King- goal attainment
  Faye Abdellah- 21 Nursing problems, Nursing is a helping profession
  Callista Roy- Adaptation
  Martha Rogers – Science, unitary human being
  Virginia Henderson – need theory
  Carl Rogers – empathy, unconditional positive regard, openness

- Catheter
  - Standard length 40-44cm
  - Female: 23-26cm
  - Pedia: 30cm
- Patient has fractured limbs with mild-moderate pain
  - Give oral paracetamol
- Underarm crutch
  - Take small steps
- Sexual belief against you
  - Carefully outline nurse's own belief
- Removing close drainage system
  - Clamp tubing from the patient & open clamp or connector
- Veracity – being truthful
  Beneficence – act of doing good
  Non-maleficence – doing no harm
  Fair – just
- 65 y.o. above
  - Alzheimer's (Dementia)
- DM I only – ketones in urine

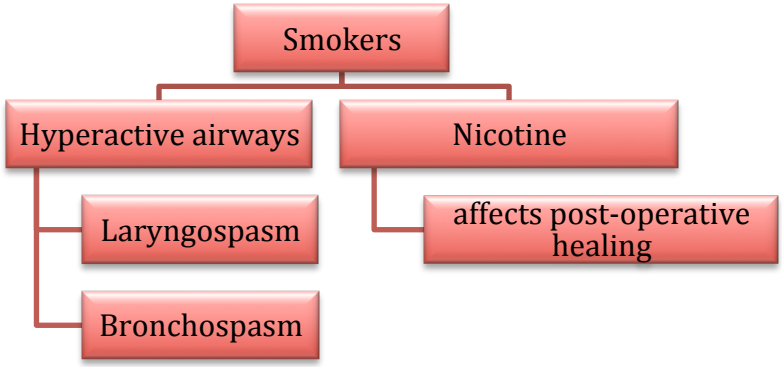
	DM I	DM II
Diagnosis	Young	Old
Weight	Lose	Gain (excess)
Urine	Ketones	-
Cholesterol	-	High
Treatment	Insulin injection Life long	Oral

- PGD, Except?
  - Any type of person included in the treatment
- Must not be given as instruction in the use of walking aid?
  - Use arms to stand from the chair
- Elderly patient with fluid volume deficit, all but one:
  - Distended neck veins when supine
- WHO Analgesic Ladder
  - Level 1 – non-opioids – NSAIDS, corticosteroids
  - Level 2 – weak opioids – codeine
  - Level 3 – strong opioids – morphine, acetaminophen, lorazepam
- GOUT
  - Low Purine diet
  - Exercise - POFI
  - Avoid energy drinks or caffeine

- RN is excluded from legal action in which one?
  - Possessing stolen medications
- Least likely intervention to Diabetes Mellitus?
  - Increase relaxation
- Sickle cell anemia
  - Assess the pain & use age appropriate
- Neutropenia
  - Watch out for: Infection
- Acute Glomerulonephritis (AGN)
  - Dyspnea – fluid retention
- Never delegate to student?
  - PGD's
- Person-centered care
  - Help improve the quality of the services available
  - Help innovate people's health & reduce the burden on health services
  - Help people get care when they need it
  - Improve people to secure active in looking after themselves
- Common types of infection in 2012
  - Respiratory tract infection
  - Meningitis
  - UTI
  - Gastroenteritis
  - Surgical site infection
    - Not included (except) Bacteremia
- Dysphasia
  - Brain disease or brain damage
  - Difficulty in speech and communication
- Dysarthria
- Dyspraxia
  - Disorder with planning, initiating & sequencing purposeful or voluntary
- Dysphonia
  - Physical disorder with the mouth/tongue/throat/vocal chords
- CONSTIPATION CATEGORIES
  - Primary – lifestyle
  - Secondary – underlying medical condition
  - Iatrogenic – medications
- Diarrhea
  - 6-8 times a days
  - Recovery 2 days after
  - Required additional 200 ml for each loose stool
- Newly formed stoma
  - Eat varied diet
- BODY MASS INDEX (BMI)
  - 18 - 24.9 = Healthy
  - 25 - 29.9 = Overweight
  - 30 – 39.9 = Obese
  - 40 and above = severely obese
  - under 18 – underweight

- Infusion time
  - $\frac{\text{Volume}}{\text{Flow rate}}$ x drop factor
  - ex: $\frac{800\text{ml}}{40\text{gtts}}$ x 15gtts = $\frac{300\text{mins}}{60\text{mins}}$ = 5hrs

- Window period of HIV
  - 3 months
- Route most likely to cause allergic reaction?
  - Topical
    - 2nd- Paracetamol
    - 3rd- Oral
- Most common cause of errors
  - Failure to correctly identify dosage
- Beta-blockers
  - Medications that can be given up to 2 hours before surgery with a sip of water
- When exploring with smoking & drug alcohol uses with the patient. What should the RN tolerate as it is acceptable?
  - Male: 25 units
  - Female: 14 units per week
- What danger can a history with smoking for diagnosis a patient scheduled for surgery?



- RN wants to involve a patient in a program to quit smoking
  - Care core plans
- Timing with the education
  - Most crucial & can influence with patient ability to retain pre-operative information
- Liaise between the patient & the healthcare team
- Not part of the IMCA roles to patient?
  - Safeguards night with people who wants to sell their home
- Situation where it may be appropriate for the RN to instruct IMCA?
  - A family member or friend may refuse to be consulted. There is abuse by the family member or friend
- NMC came up with the Code of Conduct for nurses and midwives in order to?
  - Provide professional guidance that underpin the practice with Nurses & Midwives
- Post-operative patient, RN priorities?
  - Relief of pain

- STAGE 2 pressure ulcer
  - Stage of pressure ulcer which involves loss of dermis, deep ulcer without slough
- Young woman with HIV, what to do?
  - Encourage the patient to disclose this information to her physician
- Eukaryocyte
  - Not a characteristic of bacteria
- Dispersal
  - Not a stage in the life cycle of viruses
    - Viruses Life Cycle
      1. Attachment to Host
      2. Penetration – enters the host cell
      3. Uncoating – breaks down & exposes virus
      4. Replication – create more viral particles
      5. Release – release from the cell
- CJD, Nursing Management
  - Initiating isolation procedures
- Before commencing direct patient care, the RN must?
  - Perform handwashing using 6 steps techniques
- Which of the following is not part of the common problem associated with penile sheaths?
  - Difficulty fitting as penile sheaths are constraint-coated for very large or retracted penis
- 3 most significant life threatening emergency situations with tracheostomy tube include?
  - Blockage, displacement, hemorrhage
- Most important principle that underpins the use of anesthetic lubricating in catheterization?
  - Trauma can occur during catheterization with patient which in turn can increase their risk of infection & using single-use lubricating gels with antiseptic properties can decrease these risks
- Least factor to contribute to promoting a safe care environment?
  - Keeping the environment cool enough to promote ventilation
- General principles of care with complex neurological impairments, except?
  - Patient with little limb fixation secondary to soft tissue changes & contractures are at risk of hypotonia
- Poor nutrition/fluid intake
  - Behavioural risk factor when assessing the potential risk of falling in an older person
- Ensure spinal & limb alignment
  - Ensure patient is lying centrally in the bed
- Not true about compartment syndrome
  - .
- Proper use of zimmer frame?
  - To sit, instruct patient to back up until legs touch the chair then use hands to feel the seat behind them
- Not part of appropriate use of zimmer frame
  - The patient can pull self-up when using the frame
- Patient with Hepatitis A, Need for further teaching?
  - "I can share my towel & blankets with my family

- Patient showing sexual beaviours toward him/her
  - Talk to the patient, attempt to reestablish professional relationship.
  - Talk to the line manager
- Dr. tells the patient that the treatment is not working, Nurse must do?
  - Ask patient if he wants to discuss what the doctor said.
- Urine free cortisol test 24hrs is done because?
  - Cortisol is secreted in constant amount throughout the day needing whole 24-hour collection
- Why is person centered care valued in the NHS?
  - Research has formed that person-centered care can help to improve people's health & reduce the burden on health service.
- Putting people at the center of their care will?
  - Help improve the quality of the services available
- Courage – personal strength
  - Speak up when they have concerns
- Clinical Audit
  - Measurement of healthcare service against standards & the way to know if patients & health care providers find the care in doing well & where core can be improved in order to promote clinical effectiveness & clinical governance
- MRSA, all but one is a high risk assessment for source isolation to prevent its spread in healthcare?
  - Positive screening swabs, but otherwise well
- All but one, most common types of infection?
  - Bacteremia
- Elderly patient admitted to Acute Assessment Unit: disoriented, in distress & have impaired consciousness & attention:
  - Delirium (acute)

ROYAL MARSDEN (MCQ's)

- Hypotension, adverse effects
  - Decreased level of consciousness, oliguria, decreased coronary blood flow
- Type 1 (Hypoxaemic) Respiratory failure
  - Asthma
  - Pulmonary edema (except: drug overdose)
  - Granulomatous lung disease

DRUG CALCULATION

- $\frac{\text{Desired}}{\text{Stock}} \times \text{Quantity}$

Conversions:
1 gram = 1000mg
1mg = 1000mcg
1mcg = 1000nanograms
1kg – 2.2lbs

1. D – 1000mcg
   S- 4mg
   Q- 1 tab

   $\frac{1mg}{4mg} \times 1 = 0.25$ tab

2. D – 2mg/kg for a child weighing 97 lbs
   S – 175mg/2ml

   $\frac{97lbs}{1} \times \frac{1kg}{2.2lbs} = \frac{97\ lbs}{2.2lbs} = 44.09$ kgs

   44.09kgs x 2mg = 88.18mg

   $\frac{88.18mg}{175mg} \times 2ml = 1ml$

3. D – 1g
   S – 325 mg

   1000mg / 325mg = 3mg

4. D – 500mg
   S – 1gm/tab

   500mg / 1000mg = 0.5tab

5. D – 75mcg
   S – 0.15 mg/tab

   $75mcg \times \frac{1mg}{1000mcg} = 0.0075mg$

   $\frac{0.075mg}{0.15\ mg} = 0.5$ tab

6. D – 7.5 mg/kg, 157lbs
   S – 0.35 g/ml

   $7.5mg \times \frac{1g}{1000mg} = 0.0075g$

   $157lbs \times \frac{1kg}{2.2lbs} = 71.36$ kg

   0.0075g x 71.36kg = 0.54g

   $\frac{0.54\ g}{0.35g} \times 1ml = 1.5ml$

PRACTICE QUESTIONS COMPILED BY ALI JONES 2016

- Handling the specimen container labelled with a yellow hazard
  - Wear gloves & apron & inform the laboratory that you are sending the specimen
- How much urine should someone void an hour?
  - 0.5 – 1ml / kg / hr with the patient's body weight
- Spinal cord injury, most common cause of autonomic dysreflexia (a sudden increase in BP)
  - Urinary obstruction
- Nebulizer, flowrate
  - 6 – 8 Lpm (Minimum)
- Normal breathing, main muscle involve in inspiration
  - Diaphragm
- Human body
  - Approximately 60% water
- PISO
  - P-In, S-Out
- Patient needs assistance at meal time be identified?
  - Red sticker or color serviette, a red tray
- Blood type A can receive blood from?
  - A & O
- Dermis
  - Contains blood and lymph vessels, sweat & subcutaneous gland
- Not recommended method with mouth care?
  - Glycerin & lemon swabs
- Percentage with air we breath is oxygen
  - 21%
    - Oxygen – 21%
    - CO2 – 0.03%
    - Nitrogen – 79%
    - Rare gasses – 0.003%
- Non-rebreathing masks
  - Able to deliver 60-90% of oxygen when delivered at a flow rate of 10-15LPM
- Adrenaline
  - 1st drug of choice to be used in cardiac arrest with any etiology
- Hematoma
  - Most common complication of venipuncture
- Prioritize people, preserve safety, practice effectively, promote professionalism & trust
- A central venous access device presents a high risk of infection - incidence of bacteremia between 4-8%
- "I haven't been able to straighten the fingers on my right hand since this morning (right arm cast)
  - Assess neurovascular status of the hand
- 5 phases of Korotkoff sounds
- Gillick competent
  - Children under the age of 16 Who are believed to have intelligence, competence & understanding to fully appreciate what's involved in their treatment

- After lumbar puncture patient becomes unconscious
  - Cerebrospinal fluid leakage (loss of consciousness, motor changes,
- Increased ICP
  - Except lumbar puncture because of risk in brain herniation
- Headache, lumbar puncture size of needle:
  - 25G blunt ended
- Phases of wound healing
- Error in documenting
  - Draw line through error, write initial, date & document correct information
- Right patient, drug, dose, route, time
- Diabetic patient, while making rounds, trembling & stating they are dizzy, Next action?
  - Check for blood glucose level
- The nurse in charge
  - overall responsibility for the safe & appropriate management of controlled drugs within the clinical area:
- Dose: Ibuprofen 200mg
  Stock: 400mg coated
  →made to delay the release of the drug that are inactivated by the stomach contents
  - Order the different dose of tablet from pharmacy
- Primary care
  - Healthcare provided in the community for people making an initial approach to a medical practitioner or clinic for advice or treatment
- Speed shock
  - Circulatory collapse, flushing face, headache
  - NOT peripheral edema
- Negative Pressure Wound Therapy
  - Can reduce wound odor, increase local blood flow in the periwound area, can decrease the use of dressing
  - EXCEPT untreated osteomyelitis – negative pressure is contraindicated
- Pyrexia
  - Not evident in the elderly because of immature T-cells
- Pathogen
  - Capable of causing infection
- Yellow & black stripe
  - Offensive/hygiene waste
- NEWS
  - Early detection & deterioration in the patient's VS
- Yellow
  - Adverse drug reaction color card scheme
- Orthostatic hypotension
  - Systolic BP decrease by 20mmHg
  - Diastolic BP decrease by 10mmHg

- CHAIN OF INFECTION

Links	Description of the Link in the chain
1. Microorganisms	- First link - Can spread directly or indirectly from person to person
2. Reservoir	- 2nd link - Where the microorganism is found - a place where the microorganisms have all the things they need to grow & multiply: warmth & moisture - Human make ideal reservoir for microorganisms
3. Portal of Exit	- For the infection to spread the microorganism, must leave Reservoir - Ex. Skin cells, blood, breath, body fluids or vomit
4. Mode of Transmission	- Microorganism needs Mode of transmission to get from one person to another
5. Portal of Entry	- Microorganisms gets into the other person, an entry port - Could be through the mouth, nose, cuts, broken skin or medical devices
6. Susceptible Host	- Final link - Person at risk - Patients with severe or chronic illness, patients requiring the use of medical devices & people who are very old or young

- MODIFIED "WHO" ANALGESIC LADDER

1. Non-opioid +/- Adjuvant(s)	- Acetaminophen / ASA / NSAIDS - Mild pain
2. "Weak" opioids +/- non-opioid adjuvants	- Tramadol / Codeine/ Oxycodone - Moderate Pain
3. "Strong" opioid +/- non opioid adjuvant	- Severe pain - Hydromorphone, morphine, Oxycodone, Fentanyl, Methadone, Buprenorphine

- Mean arterial Pressure (MAP)
  - $= \frac{[(2x \text{ diastolic}) + \text{systolic}]}{3}$
- Reablement/Enablement lasts for 6 weeks before further evaluation.
- Unlicensed Medicinal plant
  - PSD
- Confidentiality
  - Protection of health information of a patient
- Concept of CONFIDENTIALITY
  - With expectation that personal information shared by an individual with a healthcare provider during the course with care will be used only for its intended person.

- RIGHT in case of CONSENT, 18 years old below:
  - Children who are intellectually developed & can understand matters can give consent
- Physician takes medical records (HN + patients) out the hospital then mistakenly leaves the records in a restaurant – reporter – publish. The physician is sued for?
  - Invasion of Privacy
- Medical emergencies
  - Exception to the consent requirement
- "Yes, I see Go on"
  - Ex. The patient is offering general lead

DOMAIN Practice Test 1-5

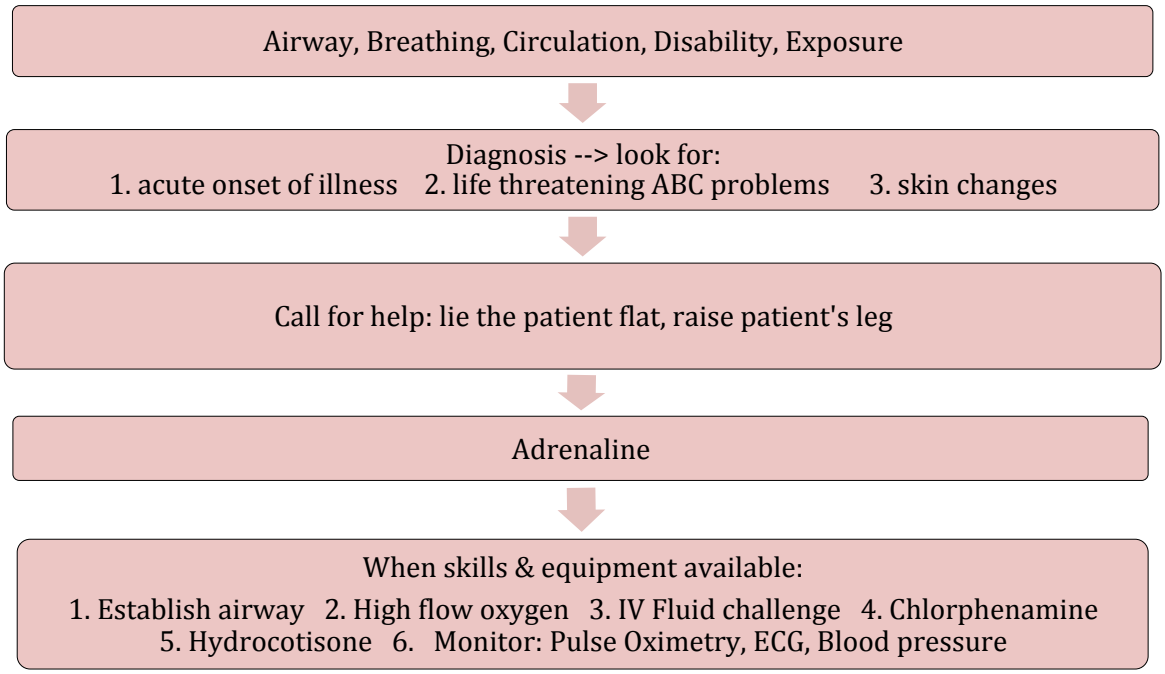
- (+) HIV, young woman, she doesn't want the Nurse to tell anyone
  - Encourage the patient to disclose the information to her physician
- Adult consent for research study, but she changed her mind
  - Autonomy & informed consent
- Nurse, not trained in IV cannulation but tries to do, Colleague must?
  - Report the incident to someone in authority
- Intrapersonal
  - Within oneself
- With the head of bed at 60 degrees or less the PHLEBOSTATIC AXIS is located at the fourth intercostal space at the mid-anterior-posterior diameter at the chest wall. This is the location of the Right atrium, where the tip of the CVP catheter would lay.
- Country Club Management
  - Nurse Managers have low concern for services & high concern for staff
- Mini Mental state examination (MMSE)
  - Test for complaints with problems with memory or other mental abilities
  - Help diagnose dementia & to help assess its progression & severity
  - Series of questions & test
  - Tests different mental abilities, including a person's memory, attention & language

PRIMARY MODES (EYE MOVEMENT CHART)

- VISUAL
  - Primarily look up/ up to side as they process information
  - Fast talkers
  - Visual memories are a lot quick
- AUDITORY
  - Left to right or vice versa (from ear to ear) as they need to hear
  - Moderate speed talker
- KINESTHETIC
  - Look down and to the right
  - They need to feel
  - Slow talkers

- Nitrous oxide (Entonox) might be considered?
  - Wound dressing changes for a short term pain relief or the removal of a chest drain for reduction of anxiety
- Key Nursing Observations, patients receiving Opioids frequently?
  - RR, Bowel Movement Record, pain assessment and score
- Impacted Earwax
  - Signs: dizziness, dull hearing, reflux, cough
  - EXCEPT sneezing
- After death, who can legally give permission for a patient's body to be donated to medical science?
  - Only the patient, if they left instruction for this.
- Inoculate the aerobic culture first
  - If doing blood collection for other tests
- Infection
  - Temp: 38.5º, shivering, tachycardia & hypertensive

ANAPHYLACTIC REACTION


Airway, Breathing, Circulation, Disability, Exposure
Diagnosis --> look for:
1. acute onset of illness 2. life threatening ABC problems 3. skin changes
Call for help: lie the patient flat, raise patient's leg
Adrenaline
When skills & equipment available:
1. Establish airway 2. High flow oxygen 3. IV Fluid challenge 4. Chlorphenamine
5. Hydrocotisone 6. Monitor: Pulse Oximetry, ECG, Blood pressure

- Dysphagia, investigation
  - Gastroscopy
- Liver biopsy, potential complications?
  - Inadvertent puncture in the pleura, blood vessels or bile duct
- Orthostatic Blood pressure measurement be indicated?
  - Patient has history of dizziness or syncope on changing position
- Hypotension adverse effects
  - Decrease conscious level, oliguria, reduced coronary blood flow
- Contraindication for use of blood glucose meter for monitoring
  - If peripheral circulation is impaired
- Why is it important to manually assess the pulse rate?
  - Amplitude, volume & irregularities cannot be detected using automated electronic methods

- Anaphylactic reactions
  - Breathing difficulty (compromise to their airway or circulation + skin & mucosal changes
- Hypovolemic shock
  - Tachycardia, anxious, increased RR & pulse rate
- The surgeon should mark the skin with indelible pen ahead of surgery
- Compartment syndrome
  - Possibility for patients positioned in Lloyd Davies position during surgery
- Patient is being monitored in PACU. How frequently BP, PR & RR must be recorded?
  - Every 5 minutes
- How soon after surgery is the patient expected to pass urine?
  - 6-8 hours
- Necrotic wound
  - Debride & apply hydrogel dressing
- Contaminated wounds
  - Not suitable for negative (-) pressure wound therapy
- Good cosmetic result following surgery
  - Tissue adhesive
- You notice an area with redness on the buttocks of an elderly patient & suspect they are at risk of developing a pressure ulcer. Most appropriate to apply?
  - Skin barrier product

STAGES OF PRESSURE SORE

STAGE	DEFINITION	
1	Discoloration (Non-blanching erythema)	- Discoloration - Sores are not open wounds - Warmer skin temperature - Skin painful but no breakdowns or tears - Reddened & does not blanch - Sore: either firmer/ softer than the area around it
2	Partial thickness skin loss Epidermis/dermis Superficial, shallow crater	- Skin breaks/open, wears away, ulcer (tender/painful) - Deeper layers - Looks like a scrape (abrasion), blister or a shallow crater, blister filled with clear fluid - Some skin may be damaged beyond repair/may die
3	Full thickness skin loss Deep crater Subcutaneous tissue but not fascia	- Tissue beneath the skin, forming a small crater - Fat may show but no muscle, tendon or bone
4	Full thickness skin loss with exposed bone, muscle and/or tendon	- Very deep, muscle & bone, extensive damage - Damage to deeper tissues, tendons & joints

		- Little/no pain due to significant tissue damage - Serious complications such as: infection to the bone (osteomyelitis) or blood (sepsis) can occur if sores progress
DEEP TISSUE INJURY		- No open wound but the tissues beneath the surface have been damaged - Skin may look purple/dark red - Blood filled blisters
UNSTAGEABLE		- Sore's stage is not clear - Base of the sore is covered by a thick layer of other tissue & pus - The base beneath can't be seen by the Dr.

- QRS Complex
  - Ventricle excitation/depolarization
- If a client is experiencing hypotension post operatively, the head is not tilted in which of the following surgeries?
  - Chest surgery
- In the late stages of Alzheimer's disease, it is better to go along with the client's reality
- Compartment syndrome
  - Develops when swelling or bleeding occur in a compartment
  - Because the fascia doesn't stretch = increased pressure on the capillaries/nerves/muscles = blood flow to muscle & nerve cells is disrupted (with oxygen & nutrients) & can be damaged
  - Most often occurs in the anterior compartment with the lower leg (calf)
  - NOT in the thigh
- Peripheral artery disease syndrome
  - Painful cramping (hip, thigh, or calf muscle) after activities
  - Leg numbness/weakness
  - Coldness in your lower leg/feet
  - Pain is the key indicator
- Glomerulus
  - Network of blood capillaries that act as filtering site of waste products from the blood
  - Filtration process: ULTRAFILTRATION
  - Receives blood from different arterioles, blood leaves = efferent arteriole
  - Blood pressure is extremely high in the glomerulus
- Hypothyroidism
- Repeating back
  - Repeating same words back to the patient
  - Signals that their focus is a legitimate topic for discussion
- Paraphrasing
  - Same content/meaning with different words
- Clarifying
  - To reduce ambiguity & help the patient define & explain the central/pivotal aspect of the issue raised

- Mental Illness
  - ICD 10 (International Classification of Disease)
- "What can we do to help you?" = open ended
  - To explore a subject, idea, experience or relationship
- Clinical supervision
  - Used to improve patient safety
  - NOT an NMC requirement for RN but supports the establishment with supervision practices in the nursing profession
- Older man, acute gout attack, MOST beneficial in decreasing the client's pain during ambulation?
  - Encourage partial weight bearing while ambulating
- Patient with CLOSTRIDIUM DIFFICILE + Diarrhea
  - Maybe CROHN's disease
- Scaphoid bone
  - Most commonly injured carpal bone
- GLICLAZIDE
  - Oral hypoglycemic drug acting to increase insulin produced by the pancreas
- Primary care
  - Day to day healthcare given by a healthcare provider
- Intermediate care
  - Range of short term treatment or rehabilitative services designed to promote independence
- Tissue Viability Nurse
- Abdominal Paracentesis (Guidelines to be considered)
  - Empty bladder to avoid puncturing (when trocar is introduced)
  - Weighing and recording the patient before the procedure to assess weight changes and fluid loss
  - Measure patient's girth around the umbilicus before procedure (indicates fluid shift & re-accumulation)
  - Supine position
- Compassion
  - We find time for patients, their families & carers, as well as those we work with
- Fever & diarrhea after 12hrs of beginning antibiotics
  - TRUE, antibiotics cause multiplication with Clostridium Difficile in the intestine causing diarrhea
- Young patient taking antibiotics
  - Don't take it with alcohol (peer pressure)
- Ectopic Pregnancy Risk Factors
  - Smoking
  - Tubal/pelvic surgery
  - Previous ectopic pregnancy
  - EXCEPT alcohol intake